# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 83a

## CERTIFICATE OF DEATH

09200

Reg. Dist. No. 8

**1. PLACE OF DEATH:**
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 64 yrs. 7 mos. Ds
Hospital, Institution, or street address where death occurred: Watercliffe
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants, give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No. Waterclyffe
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** Jane Gordon Byers Abbott

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife: William E Abbott

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Feb. 27 1876

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 7 | 0 | ...hrs. ...min. |

9. Birthplace: Lonaconing, (Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Home

FATHER
12. Name: William Byers
13. Birthplace: Scotland

MOTHER
14. Maiden name: Margaret Wilson
15. Birthplace: Scotland

16. Informant: Miss Elias Abbott
Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 29 1940 (month) (day) (year)
Cemetery or crematory: Laurel Hill Cemetery
Location: Mascow, Md.

18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.

19. Sept 29 1940 (Date rec'd by registrar) E. Dan Tyler Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 27 1940, at 3:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1939 to September 1940 and that I last saw h.. alive on September 14 1940

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Hemorrhage | |
| Hypertension | |
| Due to | |
| | |
| Due to | |
| | |
| Other conditions: Arteriosclerosis | |

(Include pregnancy within 3 months of death)

Major findings of operations: ...Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ...Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: R M Shelton Jr. M D. M. D. or other
Address: Midland, Md. Date signed 9-28-40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 8 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

09201

## CERTIFICATE OF DEATH

Reg. Dist. No. 401

**1. PLACE OF DEATH:**

County Allegany

~~City or~~ town Oldtown
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 yrs

Hospital, institution, or street address where death occurred: Oldtown, Md.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Oldtown
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Bertha Edith Adams.

**3. (b) Social Security Number**

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Chas Price Adams

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb 27 1881

**8. AGE:** Years 59 | Months 7 | Days 23 | If less than one day ..... hrs. ..... min.

9. Birthplace: Oldtown, Md.,
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Chas F Twigg
13. Birthplace: Md.

MOTHER
14. Maiden name: Hannah C Goldborough
15. Birthplace: W. Va.

16. Informant: Hazel Adams
Address: Oldtown, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 22 40 (month) (day) (year)

Cemetery or crematory: Ft Ashby Cem #

Location: Ft Ashby, W. Va.

18. Funeral director: Louis Stein Inc
Address: Cumberland.

19. 9/23/ 1940 (Date rec'd by registrar) Mrs C A Shanholtz Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 20 1940, at 7 40/a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April-15 1940, to Sept 20 1940 and that I last saw her alive on Sept 19 1940

| Immediate cause of death | DURATION |
|---|---|
| Chronic Myocarditis | 1 yrs |
| Chronic nephritis | 1 yr |
| Due to Hypertension | 5 yrs |
| Arteriosclerosis | 5 yrs. |
| Due to He | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: H A Edison MD
M. D. or other

Address: 126 Union St. Cumberland Date signed 9/20/40

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

## CERTIFICATE OF DEATH

09202

Reg. Diat. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 63 yrs
Hospital, Institution, or street address where death occurred:
106 Altamont Terrace
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 106 Altamont Terrace
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** Vernon Sinclair Adams

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6.(b) Name of husband or wife: Bessie Adams
6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): August 23 1877

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 1 | 7 | hrs. min. |

9. Birthplace: Cumberland Md (Town, county, and state)
10. Usual occupation: auditor (Retired)
11. Industry or business: Coal Company
FATHER 12. Name: Alexander Adams
13. Birthplace: Cumberland Md
MOTHER 14. Maiden name: Helen Wineow
15. Birthplace: Cumberland Md
16. Informant: Mrs. Alexander Adams
Address: LeVale, Cumberland Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct 2/40 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Cumberland Md
18. Funeral director: William H. Kight
Address: Cumberland Md
19. Oct. 1 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 30 1940, at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 20 1940 to Sept 30 1940 and that I last saw him alive on Sept 29 1940

| Immediate cause of death | DURATION |
|---|---|
| Uremic Poisoning | 1 Week |
| Due to (Cause) Chronic Nephritis | 3 yrs |
| Other conditions Organic Heart Disease Arteriosclerosis | 3 yrs |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Edw. H. Kight M. D. or other
Address: Cumberland Md Date signed: 10/1/40

Dr Koon.

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (169) CP

09203

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: 420. Springdale St

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 8 Hours

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: W Va County: Hampshire

City or town: Points W Va Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Jesse Taylor Arnold

**3. (b) Social Security Number:** 705-12-4912

4. Sex: M

5. Color or race: W

6. (a) Single, married, widowed, or divorced: Single

6 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): January 20 1911

8. AGE: Years 29 Months 8 Days 0 If less than one day: hrs. min.

9. Birthplace: North River Mills W Va (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Farming

FATHER
12. Name: Wm Arnold
13. Birthplace: Slanesville W Va

MOTHER
14. Maiden name: Delia Fultz
15. Birthplace: Junction W Va

16. Informant: Mrs Delia Arnold

Address: 420. Springdale St City

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 23/40 (month) (day) (year)

Cemetery or crematory: Wesley Chapel

Location: Points W Va

18. Funeral director: William H Kight

Address: Cumberland Md

19. 9/23/ 1940 (Date rec'd by registrar) Joseph C. Franklin M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: September 20th., 1940, at 7.20 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 19 , to 19 , and that I last saw h alive on 19 .

Immediate cause of death: Fractured skull, Great, gaping wound of upper chest, exposing mediastinum.

DURATION:

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: accident Date of: 9/20/40

Where did injury occur? Cumberland, Allegany, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): R.R. Yards

Means of injury: struck by a train Injured at work? no

23. SIGNATURE: Louise H. Corson, M.D. M. D. or other

Address: Cumberland, Maryland. Date signed: 9/21/40

Deputy Medical Examiner - Allegany Co.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
SEP 27 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

## CERTIFICATE OF DEATH

09204

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution or street address where death occurred: Memorial Hospital
How long in hospital or institution? [redacted]

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 713 BEDFORD ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3. (a) FULL NAME** MABEL BABST

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| FEMALE | WHITE | SINGLE |

6.(b) Name of husband or wife
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) AUGUST 12, 1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 53 | 1 | 19 | hrs. min. |

9. Birthplace DEFIANCE, PA. BEDFORD COUNTY (Town, county, and state)
10. Usual occupation Housewife
11. Industry or business

FATHER
12. Name CHARLES BABST
13. Birthplace GERMANY

MOTHER
14. Maiden name ELIZABETH GETTLEMAN
15. Birthplace PA.

16. Informant WILLIAM BABST
Address 713 BEDFORD ST., CITY

17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept 3, 1940 (month) (day) (year)
Cemetery or crematory HOPEWELL, PA.
Location HOPEWELL, PA.
18. Funeral director Robert E. Hoffo
Address Saxton Pa.
19 Sept 3 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH SEPTEMBER 1 19 40 at 7:27 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 6 19 40 to Sept. 1 19 40
and that I last saw her alive on Sept 1 19 40

| Immediate cause of death | DURATION |
|---|---|
| Carcinomatosis | ? |
| Due to: Carcinoma of breast. | |
| Due to: Operation 1934 | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operation Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Jno F. Williams M. D. or other
Address Cumberland Date signed 9-2-40

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (17-E)

## CERTIFICATE OF DEATH

09205

Reg. Dist. No. X-1

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Allegany
City or town Oldtown
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Oldtown Md.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md County Allegany
City or town Oldtown Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Lewella Barth

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Nov 9 1885

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 54 | 9 | 24 | hrs. min. |

9. Birthplace Oldtown Md
(Town, county, and state)
10. Usual occupation none
11. Industry or business
FATHER 12. Name Lewis H. Barth
13. Birthplace Md
MOTHER 14. Maiden name Louise Wagner
15. Birthplace Md.
16. Informant Mr John H Davis
Address Oldtown Md
17. ~~Bu~~ Burial Date thereof Sept 5 40
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Wagner Cemetary
Location Oldtown Md.
18. Funeral director Lewis Steinbrunner
Address Cumberland, Md.
19. 9/5/40 19 Mrs C. A. Shinkle
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Sept. 3 1940, at 1230 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to Sept. 3 1940, and that I last saw her alive on August 19__.

Immediate cause of death: Lobar Carcinoma of Left Lung
Patient never menst.
Due to Mental Deficiency

DURATION: 14 yrs all her life

Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Chas. H. Brown M. D. or other
Address Cumberland Md Date signed 9/3/40

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

## CERTIFICATE OF DEATH

09206

Reg. Dist. No. 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Flintstone
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days): 70

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: Allegany
City or town: Rural Flintstone R No. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Arthur Clifton Bennett

**3. (b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | White | Single |

6 (b) Name of husband or wife
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Aug 31 1869

8. AGE: Years: 71 | Months: 0 | Days: 14 | If less than one day: hrs. min.

9. Birthplace: Pa (Town, county, and state)

10. Usual occupation: Laborer

11. Industry or business:

FATHER
12. Name: John Bennett
13. Birthplace: Pa

MOTHER
14. Maiden name: Catherine Himes
15. Birthplace: Pa

16. Informant: Minnie Murphy
Address: Flintstone Md

17. Buried (Burial, cremation, or removal. Which?) Date thereof Sep 16 1940 (month) (day) (year)
Cemetery or crematory: Mt Hope
Location: Southampton Twp Bedford Co Pa

18. Funeral director: Ephraim Smith
Address: Artemas Pa

19. Sept. 16 1940 (Date rec'd by registrar) D. Bennett Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Probably September 9th ? 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19,
and that I last saw h alive on 19.

Immediate cause of death: Coronary Thrombosis — DURATION
Body discovered to day (9/15/40) by neighbors of this man, who lived
Due to alone in the country.
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Bruce H. Benson M.D.
M. D. or other
Address: Cumberland, Maryland. Date signed: 9/15/40

Deputy Medical Examiner - Allegany Co.

RECEIVED
OCT 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1496)

09207

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 hrs

Hospital, institution, or street address where death occurred: Allegany Hospital.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Mt. Savage
(If outside city or town limits, write RURAL and give nearest town)

Street No. —
(If rural, give LOCATION)

2.(a) If veteran, name war —

**3.(a) FULL NAME** Verna Sylvia Berry

**3.(b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6.(b) Name of husband or wife: Newton E. Berry

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): November 13, 1904

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 35 | 10 | 6 | ..... hrs. ..... min. |

9. Birthplace: Spencertown ~~N.J.~~ N.Y.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Kenneth Waltermier
13. Birthplace: Frostburg, Md.

MOTHER
14. Maiden name: Gertrude Gay
15. Birthplace: N.J.

16. Informant: Mr N E Berry
Address: Mt Savage, Md.

17. burial
(Burial, cremation, or removal. Which?)
Date thereof: Sept 22 1940
(month) (day) (year)

Cemetery or crematory: Hillcrest Cemetery

Location: Cumberland

18. Funeral director: Louis Stein Inc.
Address: Cumberland, Maryland

19. 9/23/ 1940
(Date rec'd by registrar)
Joseph P. Franklin, M.D.
Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Sept 19 1940 at 6:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 16 1940, to Sept 19 1940 and that I last saw her alive on Sept 19 1940

Immediate cause of death: Embolism

Due to: Post-operative Caesarean Section

Due to:

Other conditions: Pregnancy
(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: B. M. Schindler M.D.
M. D. or other

Address: 41 Greene St Date signed: Sept 21, 1940

VS A15 (T) MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (116-a)

## CERTIFICATE OF DEATH

09208

Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 weeks
Hospital, Institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution? 5 weeks

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: West Virginia County: Mineral
City or town: Ridgeley
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 17 Mineral Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** Rebecca Miller Bradley

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6.(b) Name of husband or wife: James Gordon Bradley
6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Dec. 27, 1862

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 9 | 1 | hrs. min. |

9. Birthplace: Davis Mountain, Preston Co. W. Va.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Home
FATHER
12. Name: Samuel Miller
13. Birthplace: Davis Mountain, Preston Co. W. Va.
MOTHER
14. Maiden name: Annie Neff
15. Birthplace: County Clare, Ireland
16. Informant: Mrs. Grace McFadden
Address: Ridgely, W. Va.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 30 1940 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing, Md.
18. Funeral director: Mr. Eichhorn
Address: Lonaconing, Md.
19. Sept. 30, 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Sept. 28 1940 at 8 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 23 - 1940 to Sept. 28 - 1940 and that I last saw h[illegible] alive on Sept. 27 - 1940

| Immediate cause of death | DURATION |
|---|---|
| Shock - Myocardelitis | 5 hrs |
| Due to | |
| Due to | |
| Other conditions: Fract. Neck of Femur | 5 wks |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Accident Date of: 8-23-40
Where did injury occur? Ridgeley (City or town) W. Va. (County) (State)
Injured at home, farm, industry, public place (where?): at home
Means of injury: Fall. Injured at work? No.

23. SIGNATURE: O. F. D. Snyder M. D. or other
Address: Cumberland, Md. Date signed: 9-28-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

09209

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (22-0)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 days

Hospital, institution, or street address where death occurred: Allegany Hosp.

How long in hospital or institution? 10 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 632 No. Mechanic St (If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** Patricia Jean Buzzard

**3.(b) Social Security Number:** None

4. Sex: F

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 26, 1935

**8. AGE:** Years 5 | Months 0 | Days 21 | If less than one day ..... hrs. ..... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: —

11. Industry or business: —

FATHER
12. Name: William Buzzard
13. Birthplace: ~~Md~~ Ohio

MOTHER
14. Maiden name: Margaret Eady
15. Birthplace: Ohio

16. Informant: Wm Buzzard

Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 20-40 (month) (day) (year)

Cemetery or crematory: St Patrick's

Location: Cumberland, Md

18. Funeral director: W. L. Temperance

Address: Cumberland Md

19. 9/20/ 1940 (Date rec'd by registrar) Joseph P. Franklin M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Sept. 17, 1940, at ..... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15th 1940, to Sept 19 1940 and that I last saw her alive on Sept 17 1940

Immediate cause of death: Miliary Tuberculosis — DURATION: 3 month.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: W. Alfred Van Ormer M. D. or other

Address: Cumberland, Md. Date signed: 9-18-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 7 1940
BUREAU V. S.

# STATE OF MARYLAND—CERTIFICATE OF DEATH

09210

**1. PLACE OF DEATH**

County Allegany Registration Dist. No. 9

Village or City Frostburg No. Miners Hosp. St., Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

**2. FULL NAME** Baby Carter If U. S. Veteran, specify WAR

(a) Residence: No. St., Ward. Frostburg

(Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX Female

4. COLOR OR RACE Negrus

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word)

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year) 9/21/40.

7. AGE Years Months Days If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc.

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) (State or country) Frostburg Md.

FATHER

13. NAME Bernard Bush.

14. BIRTHPLACE (city or town) (State or country) Frostburg Md

MOTHER

15. MAIDEN NAME Ernestine Carter.

16. BIRTHPLACE (city or town) (State or country) Frostburg Md.

17. INFORMANT (Address) Mrs. Carter (Grandmother) 117 Park Ave. Frostburg Md.

18. BURIAL, CREMATION, OR REMOVAL Burial

Place Allegany Cem. Date Sept 21 St, 1940

19. UNDERTAKER (Address) Jacob Hofer Frostburg Md.

20. FILED Sept. 21, 1940 Mrs. A. R. Walker Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** Sept. (Month) 21 (Day), 1940. (Year)

22. I HEREBY CERTIFY, That I attended deceased from Sept. 21, 1940, to Sept. 21, 1940

I last saw h alive on dead 30, 19; death is said to have occurred on the date stated above, at 10 A m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Born dead.

Date of onset

Other Contributory Causes of importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury, 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) W. E. Gattens M. D.

(Address) Frostburg, Md. 10-30 A 1940 Sept 21

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

**Example I**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Arteriosclerosis* | *1915* |
| *Chronic interstitial nephritis* | *1921* |
| *Cerebral hemorrhage* | *July 5, 1927* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* |
| | |
| | |

**Example II**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Attack of epilepsy* | *1 week ago* |
| *Run over by street car* | *1 week ago* |
| *Peritonitis* | *3 days ago* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gastroenteritis* | *1 year* |
| | |
| | |

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS.

09211

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 150 Thomas St.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No.: 150 Thomas St. (If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** George Walter Clark.

**3.(b) Social Security Number:** 705-12-2493

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Mary Hedra Clark.

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): March 25, 1878

**8. AGE:** Years: 62 Months: 6 Days: 19 If less than one day: hrs. min.

9. Birthplace: Keyser West Va. (Town, county, and state)

10. Usual occupation: Engineer

11. Industry or business: B & O Rail Road

FATHER: 12. Name: George Clark.

13. Birthplace: Md.

MOTHER: 14. Maiden name: Mary Ellen Fanner

15. Birthplace: Md.

16. Informant: Mrs. G. W. Clark.

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 16 40 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland Md.

18. Funeral director: Louis Steinolm

Address: Cumberland Md.

19. Sept. 16 19 40 (Date rec'd by registrar) J. P. Franklin Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: September 14 1940 at 29 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 15 1940 to Sept. 14 1940 and that I last saw h. i. alive on Sept. 13 1940

| | DURATION |
|---|---|
| Immediate cause of death: Cerebral Embolism | 1939 |
| Chronic Myocarditis | 1936 |
| Due to: Arteriosclerosis | 1935 |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings of operations: None

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. W. Eleason M.D. M.D. or other

Address: 126 Union St. Cumberland Md. Date signed: 9/16/40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (56-d)

09212

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 8 Days

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

Street No. ALLEGANY GROVE (If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** MR. MEDFORD R. COFFMAN

**3.(b) Social Security Number** 214-05-9891.

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | WIDOWED |

6.(b) Name of husband or wife MAY KAISER

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) SEPT 23, 1878.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | 0 | 3 | ..... hrs. ..... min. |

9. Birthplace VIRGINIA (Town, county, and state)

10. Usual occupation KELLY TIRE CO.

11. Industry or business

FATHER — 12. Name JAMES COFFMAN

FATHER — 13. Birthplace VIRGINIA

MOTHER — 14. Maiden name MYRA APPERSON

MOTHER — 15. Birthplace VIRGINIA

16. Informant MEMORIAL HOSPITAL

Address CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 28, 1940. (Month) (day) (year)

Cemetery or crematory Mt. Jackson Cem.

Location Mt. Jackson, Va.

16. Funeral director D. C. Wolford

Address Cumberland Md.

19 Sept. 27 19 40 J. P. Franklin, M.D. Registrar

(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH SEPT 26, 1940 at 12:35 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from SEPT. 18 1940, to SEPT 26 1940

and that I last saw h... 1m alive on SEPT 26, 1940

Immediate cause of death Cyst of Brain — DURATION 1 Month

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results Cyst of Brain

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE L. R. Meyers M. D. or other

Address Cumberland, Md. Date signed 9/26/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

DR. MEYERS

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (926)

## CERTIFICATE OF DEATH

09213

Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 25 yrs.
Hospital, Institution, or street address where death occurred: 509 Greene St.
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 509 Greene St.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** William Renton Cooper

**3.(b) Social Security Number** None

4. Sex: Male
5. Color or race: Colored
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Louanna Willis
6.(c) If alive, give age ..... years
7. Birth date of deceased (mo., day, yr.): Aug 1875
8. AGE: Years: 65 Months: ? Days: ? If less than one day: ..... hrs. ..... min.
9. Birthplace: Harpers Ferry, W. Va.
(Town, county, and state)
10. Usual occupation: Janitor
11. Industry or business: Private Homes.
FATHER 12. Name: William Cooper.
13. Birthplace: U.S.A.
MOTHER 14. Maiden name: Sarah Moody.
15. Birthplace: U.S.A.
16. Informant: Mrs Louanna Willis
Address: Cumberland Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 27 (month) (day) 1940 (year)
Cemetery or crematory: Rose Hill Cem.
Location: Cumberland
18. Funeral director: Louis Stein Inc
Address: Cumberland.
19. 9/26/ 1940 (Date rec'd by registrar) Joseph A. Franklin M. D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Sept 24th 1940 at 11:20 P M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-24-40 19..... to 9-24- 1940 and that I last saw him alive on Sept. 23 1940
Immediate cause of death: Mitral Regurgitation — DURATION: Two yrs
Due to: Chronic Fever
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations: None
Date of op.
Autopsy results: None
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No
Accident, suicide, or homicide: — Date of
Where did injury occur? — (City or town) — (County) — (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work? —

23. SIGNATURE: J. I. Langston M. D. or other
Address: 54 N. Mechanic Date signed 9-25-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

09214

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (157-m)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 52 Elder St

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL and give nearest town)

Street No. 52 Elder St

(If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME Infant Crawford

3.(b) Social Security Number None

4. Sex Male

5. Color or race White

6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) Sept 2, 1940

8. AGE: Years Months Days Infantry If less than one day 11 hrs. min.

9. Birthplace Cumberland Md (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Leroy Crawford

13. Birthplace Md. Cumberland

MOTHER 14. Maiden name Laura Swick

15. Birthplace West Va. Petersburg

16. Informant Mr Leroy Crawford

Address 52 Elder St. Cumberland, Md

17. Burial. (Burial, cremation, or removal. Which?) Date thereof Sept 4, 40 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director Louis Stein Inc

Address Cumberland, Md.

19. Sept 4 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Sept 3 1940 at 9 a M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 2 1940 to Sept 3 1940 and that I last saw him alive on Sept 3 1940

Immediate cause of death Developmental Abnormalities

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? No (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE M. S. Owen M. D. or other

Address 138 Vic Ave Date signed 9/3/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15 (T)

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-C)

09216

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 514 Rose Hill Ave

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Md
(If outside city or town limits, write RURAL and give nearest town)

Street No. 514 Rose Hill Ave -
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME:** Eduard A. Dawson

**3. (b) Social Security Number:** 172-03-0645

4. Sex: male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Ethel M. Nesbitt

6.(c) If alive, give age: 51 years

7. Birth date of deceased (mo., day, yr.): April 5, 1889

**8. AGE:** Years: 51 Months: 4 Days: 5 If less than one day: hrs. min.

9. Birthplace: Ocean Md.
(Town, county, and state)

10. Usual occupation: Agent -

11. Industry or business: Fuller Brush - Co -

FATHER
12. Name: John Dawson
13. Birthplace: Md -

MOTHER
14. Maiden name: Hunigundia Dallhoff
15. Birthplace: Mistilbach Germany

16. Informant: Dorothy Louise Dawson

Address: 514 Rose Hill Ave

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 12, 1940 (month) (day) (year)

Cemetery or crematory: Hill Crest -

Location: Cumberland Md

18. Funeral director: Louis Stein Inc

Address: Cumberland Md -

19. Sept. 11, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 10 1940 at 12 40 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1940 to Sept 10 1940 and that I last saw him alive on Sept - 9 1940

| Immediate cause of death | DURATION |
|---|---|
| Chronic Myocarditis | 2 yrs |
| Chronic Nephritis | 2 yrs |
| Due to: Arteriosclerosis | 3 yrs. |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: H. W. Eleason M.D. M. D. or other

Address: 126 Y Mon St. Cumberland Md Date signed: 9/11/40

VS A15 (T)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (77)

09215

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 301. Decatur St
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days): 67 yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 301. Decatur St
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Lydia Hitchcock Deneen
**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Single |

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.): October 28, 1873

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 66 | 10 | 13 | hrs. min. |

9. Birthplace: Cumberland Md (Town, county, and state)
10. Usual occupation: School Teacher
11. Industry or business: Public School
FATHER 12. Name: John B. Deneen
13. Birthplace: Cumberland Md
MOTHER 14. Maiden name: Helen Talliott
15. Birthplace: Mt Savage Md
16. Informant: Miss Sophia Deneen
Address: 301. Decatur St City
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 13. 1940 (month) (day) (year)
Cemetery or crematory: Rose Hill
Location: Cumberland Md
18. Funeral director: William H. Right
Address: Cumberland Md
19. Sept. 12 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Sept 11 1940, at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-30- 1939 to 9-11- 1940 and that I last saw h[illegible] alive on 9-3- 1940.

Immediate cause of death: Essential Hypertension Arteriosclerosis — DURATION: 7
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury — Injured at work?

23. SIGNATURE: Jno. J. Williams M. D. or other
Address: Cumberland Date signed 9-11-40

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09217

Reg. Diat. No. 9

**1. PLACE OF DEATH:**

County Allegany

City or town Frostburg
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days) 1 wk

Stay in this community (yrs., or mos., or days) Life

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Garrett

City or town Bittinger Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Evelyn Mae Eisler

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife Grace E Eisler 35
Samuel Eisler (c) If alive, give age 35 yrs years

7. Birth date of deceased (mo., day, yr.) Dec 9, 1926

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 13 yrs | 9 | 21 | hrs. min. |

9. Birthplace Bittinger Md.
(Town, county, and state)

10. Usual occupation School

11. Industry or business

FATHER
12. Name Samuel Eisler
13. Birthplace Garrett Co Md

MOTHER
14. Maiden name Grace Arnold
15. Birthplace Greenville Township Pa

16. Informant Samuel Eisler
Address Bittinger, Md Oct 3, 40

17. Oct. 3, 1940 (Burial, cremation, or removal, Which?) Date thereof Burial (month) (day) (year) 40

Cemetery or crematory Cemetary Greenville

Location Greenville, Pa.

18. Funeral director Jacob Hafer

Address Frostburg

19. Oct. 2 1940 (Date rec'd by registrar) Mrs R. R. Hafner Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Sept. 30 1940, at 11:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 20 1940, to Sept. 30 1940, and that I last saw her alive on Sept. 30 1940.

| Immediate cause of death | OURATION |
|---|---|
| Peritonitis | 2 days. |
| Due to Perforation typhoid ulcer. | |
| Typhoid fever. | 3 weeks. |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. E. Gatten M.D.
M. D. or other

Address Frostburg, Md. Date signed 10/1/40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
NOV 2 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

# CERTIFICATE OF DEATH

Reg. Dist. No. 09218 9

**1. PLACE OF DEATH:**

County: Allegany

City or town: Frostburg Md.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days): 28 day

Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Vale Summit Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Margaret E. Fatkin

**3. (b) Social Security Number:** None

4. Sex: Female

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Single

8 (b) Name of husband or wife

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): ? ? ?

**8. AGE:** Years: 83 Months: ? Days: ? If less than one day: ? hrs. ____ min.

9. Birthplace: Vale Summit, Allegany Cty., Md.
(Town, county, and state)

10. Usual occupation: not capable of any occupation

11. Industry or business

FATHER
12. Name: Thomas Fatkin
13. Birthplace: Scotland

MOTHER
14. Maiden name: Barbara Robinson
15. Birthplace: Scotland

18. Informant: Mrs David Thomas

Address: Carlos, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 18, 1940 (month) (day) (year)

Cemetery or crematory: Vale Summit Cemetery

Location: Vale Summit, Md.

18. Funeral director: J. J. Durist

Address: Frostburg, Md.

19. Sept. 18th 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 16 1940, at 1:10 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 19 1940, to Sept 16 1940, and that I last saw her alive on Sept 15 1940.

Immediate cause of death: Arteriosclerosis Senility

DURATION: ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ____ Injured at work?

23. SIGNATURE: W. O. McLane Jr. M.D. (M. D. or other)

Address: Frostburg Md Date signed: 9-17-40

RECEIVED
OCT 2 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

09219

## CERTIFICATE OF DEATH

Reg. Dist. No. 8

**1. PLACE OF DEATH:**
County Allegany
City or town Lonaconing
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Furnace Street
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 7 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County, Allegany
City or town Lonaconing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Furnace Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

**3. (a) FULL NAME** Mary A. Bradley Foye

**3. (b) Social Security Number** —

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife Leander Foye
6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) June 9, 1866

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 3 | 2 | hrs. min. |

9. Birthplace Barton, Allegany Co., Md.
(Town, county, and state)
10. Usual occupation Housework
11. Industry or business None

FATHER
12. Name Joseph Bradley
13. Birthplace England

MOTHER
14. Maiden name Phoebe Nichols
15. Birthplace England

16. Informant Benjamin Foye
Address Lonaconing Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 14, 1940 (month) (day) (year)
Cemetery or crematory Laurel Hill Cemetery
Location Mocanaqua, Md.

18. Funeral director Mr. Eichhorn
Address Lonaconing Md.

19. Sept 12 1940 E. Dom Taylor
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 11 1940 at 6.40 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 8 1940 to Sept 11 1940, and that I last saw h[illegible] alive on Sept 10 1940.

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Hemorrhage | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Henry M. Hodgson M.D.
M. D. or other
Address Lonaconing, Md. Date signed Sept. 12 '40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 8 1940
BUREAU OF S

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (131-a)

# CERTIFICATE OF DEATH

Reg. Dist. No. 09220

**1. PLACE OF DEATH:**
County: allegany
City or town: Frostburg
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md. County: allegany
City or town: Frostburg Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 193 Bowery
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

3. (a) FULL NAME: Joanna Fram
3. (b) Social Security Number: None

4. Sex: F
5. Color or race: W
6. (a) Single, married, widowed, or divorced: widowed
6 (b) Name of husband or wife: James R. Fram
6(c) If alive, give age ____ years
7. Birth date of deceased (mo., day, yr.): Dec 10 - 1869
8. AGE: Years 70 | Months 9 | Days 4 | If less than one day ____ hrs. ____ min.
9. Birthplace: Frostburg - alleg - md.
(Town, county, and state)
10. Usual occupation: housewife
11. Industry or business
FATHER
12. Name: Joseph Preston
13. Birthplace: md.
MOTHER
14. Maiden name: unknown
15. Birthplace
16. Informant: Richard Fram
Address: Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 14 - 1940 (month) (day) (year)
Cemetery or crematory: allegany
Location: Frostburg, Md.
18. Funeral director: J J Durst
Address: Frostburg, Md.
19. Sept. 14 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 12, 1940, at 5:30 A M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1 1940, to Sept. 12, 1940, and that I last saw her alive on Sept. 12, 1940.

| Immediate cause of death | DURATION |
|---|---|
| Cardio-vascular renal disease | 3 yrs. |
| Due to arterio sclerosis | 10 yrs. |
| Due to Chronic cholecystitis | 5 yrs. |
| Other conditions Umbilical hernia | 20 yrs. |

(Include pregnancy within 3 months of death)
Major findings:
Of operations: X
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ____ Date of ____
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury ____ Injured at work?

23. SIGNATURE: H. C. Diehl, M.D. M. D. or other
Address: Frostburg, Md. Date signed: 9/14/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09221

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 years

Hospital, institution, or street address where death occurred: 422 Baltimore

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 422 Balto Ave
(If rural, give LOCATION)

2.(a) If veteran, name war: No

**3. (a) FULL NAME:** Muriel Warner Fuller

**3. (b) Social Security Number:** 214-16-2632

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Single |

6.(b) Name of husband or wife: Single

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Jan 30, 1921

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 19 | 7 | 12 | ..... hrs. ..... min. |

9. Birthplace: Cumberland, Md
(Town, county, and state)

10. Usual occupation: Clerk

11. Industry or business: 5 & 10 ¢ Store

FATHER
12. Name: Truman C. Fuller
13. Birthplace: Cumberland Md

MOTHER
14. Maiden name: Emily Kimmel
15. Birthplace: Cumberland Md

16. Informant: Truman C. Fuller
Address: Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 14 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland, Md.

18. Funeral director: Jacob Gofes

Address: Cumberland

19. 9/13/ 1940 (Date rec'd by registrar) Joseph R. Franklin Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 12 1940 at 1:05A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from January 11 1940 to 9-12-1940

and that I last saw h[illegible] alive on 9-11-40 1940

Immediate cause of death: Pulmonary T.B.

| DURATION |
|---|
| 2 yrs. |

Due to: —

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: [signature] M. D. or other

Address: ..... Date signed: 9-13-40

Dr Zim

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

# CERTIFICATE OF DEATH

09222 9

Reg. Dist. No.

**1. PLACE OF DEATH:**

County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 12 hrs

Hospital, Institution, or street address where death occurred: Miners Hosp

How long in hospital or institution? 12 hrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:** Garrett Co.
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.: R.F.D. 2
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** Baby Girl Garlitz

**3.(b) Social Security Number**

4. Sex: W

5. Color or race: W

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): SEPT. 25. 1940

**8. AGE:** Years | Months | Days | If less than one day: 12 hrs. 15 min.

9. Birthplace: Miners Hosp Frostburg Allegany Co Md
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Vernard Garlitz
13. Birthplace: Garrett Co Md.

MOTHER
14. Maiden name: Arlena Burdach
15. Birthplace: Garrett Co Md.

16. Informant: Vernard Garlitz
Address: R.F.D 2 Frostburg Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Sept. 26 - 40
(month) (day) (year)

Cemetery or crematory: Blucker Cemetery

Location: Garrett Co. Md

18. Funeral director: Vernard Garlitz (Father)
Address: Garrett Co. R.F.D #2 Frostburg Md.

19. Sept. 26 1940
(Date rec'd by registrar)
Mrs. A.R. Walker
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 26 1940, at 9 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 26 1940 to Sept 26 1940 and that I last saw her alive on Sept 26 1940

Immediate cause of death: Premature Birth

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work?

23. SIGNATURE: A M Earle Jr MD
M. D. or other

Address: Frostburg Md Date signed: 9-26-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09223

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: ALLEGANY
City or town: CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 5 Days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: MARYLAND County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 411 FURNACE ST.
(If rural, give LOCATION)
2.(a) If veteran, name war.

**3.(a) FULL NAME**
MR. LOUIS GILLARD

**3.(b) Social Security Number**
None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | MARRIED |

6.(b) Name of husband or wife: FLORENCE PAUL

6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): JULY 4 1865

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 75 | 2 | 2 | ...hrs. ...min. |

9. Birthplace: BELGIUM (Town, county, and state)

10. Usual occupation: (RETIRED)

11. Industry or business

FATHER
12. Name: HUBERT GILLARD
13. Birthplace: BELGIUM

MOTHER
14. Maiden name: ANTOINETTE DELHAUSE
15. Birthplace: BELGIUM

16. Informant: HUBERT L. GILLARD
Address: CUMBERLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 9-40 (month) (day) (year)
Cemetery or crematory: St Peter & Paul
Location: Cumberland Md
18. Funeral director: V. L. Leasenberry
Address: Cumberland, Md.
19. Sept 9 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

**MEDICAL CERTIFICATION** 3:20

20. DATE OF DEATH: SEPT 6, 1940 at pM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-24- 1940, to 9-6- 1940
and that I last saw him alive on SEPT 6, 1940

| Immediate cause of death | DURATION |
|---|---|
| Myocardial Degeneration | |
| Arteriosclerosis | |
| Due to | |
| | |
| Due to | |
| Other conditions: Benign Hypertrophy Prostate | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Howard W. Tolson M.D. M. D. or other
Address: Cumberland Md. Date signed: 9-6-40

DR. TOLSON

RECEIVED
OCT 7 1940
BUREAU Y. S.

Outside of City Limits

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

# CERTIFICATE OF DEATH

09224

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Klotzmans Addition near Cumb.

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 yrs.

Hospital, Institution, or street address where death occurred: Near Cumberland

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Klotzmans addition Near Cumb.

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Klotzmans addition La Vale

(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** But Grady

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6.(b) Name of husband or wife: Ida Fishell Grady

6.(c) If alive, give age: 59 years

7. Birth date of deceased (mo., day, yr.): July 11, 1863

8. AGE: Years: 77 | Months: 2 | Days: 0 | If less than one day: ...hrs. ...min.

9. Birthplace: Cape Cod, Mass (Town, county, and state)

10. Usual occupation: Glass Worker

11. Industry or business: Md. Glass Co.

FATHER — 12. Name: John Grady

13. Birthplace: Mass.

MOTHER — 14. Maiden name: [illegible] Adams

15. Birthplace: Mass

16. Informant: John H. M. Fishell

Address: Narrows Park. Rt #1.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 14 1940 (month) (day) (year)

Cemetery or crematory: Zion Memorial Burial Park

Location: Cumberland, Md

18. Funeral director: Jacob Hafer

Address: Cumberland, Md

19. 9/13/1940 (Date rec'd by registrar) J. R. Frankhouser Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 11 1940 at 7:P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1940, to Sept 11 1940

and that I last saw him alive on Sept 8 1940

| Immediate cause of death | DURATION |
|---|---|
| Cardiac Decompensation | 3 months |
| Due to: Chronic Myocarditis | ? |
| Due to: Arteriosclerosis | ? |
| Other conditions: — | |

(Include pregnancy within 3 months of death)

Major findings of operations: — Date of op.: —

Autopsy results: None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): —

Means of injury: — Injured at work?

23. SIGNATURE: W Royce Hodge, M.D. M. D. or other

Address: Cumberland, Md Date signed: 9/12/40

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

09225

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-6)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? 5 DAYS

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town MIDLAND
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** THOMAS GRAY

**3.(b) Social Security Number** None

4. Sex MALE

5. Color or race WHITE

6.(a) Single, married, widowed, or divorced MARRIED

6.(b) Name of husband or wife ANNA SPIKER GRAY

6.(c) If alive, give age 50 years

7. Birth date of deceased (mo., day, yr.) MARCH 24, 1889

8. AGE: Years 51 Months 5 Days 26 If less than one day ..... hrs. ..... min.

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation SALOON KEEPER

11. Industry or business

FATHER
12. Name FRANK GRAY
13. Birthplace MARYLAND

MOTHER
14. Maiden name AGNES DOUGLAS
15. Birthplace MARYLAND

16. Informant MRS. ANNA GRAY

Address MIDLAND, MD.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 23 1940 (month) (day) (year)

Cemetery or crematory Laurel Hill Cemetery

Location Moscow Md

18. Funeral director M. Eichhorn

Address Lonacony Md

19. Sept 23 1940 (Date rec'd by registrar) Joseph P. Franklin, Registrar

W F Wms

### MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 20, 1940, at 9:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-15- 1940, to 9-20- 1940 and that I last saw him alive on 9-20- 1940

Immediate cause of death: Chronic rheumatic heart disease — DURATION ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. F. Williams M. D. or other

Address Cumberland Date signed 9-23-40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

S

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

09226

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? STILLBORN

Hospital, Institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution? STILLBORN

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State HANCOCK County MARYLAND

City or town WASHINGTON CO.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME** BABY BOY GRIFFIN (STILLBORN)

**3.(b) Social Security Number**

4. Sex: MALE

5. Color or race: WHITE

6.(a) Single, married, widowed, or divorced: STILLBORN

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPTEMBER 3, 1940

8. AGE: Years | Months | Days | If less than one day hrs. min.
Stillborn

9. Birthplace Cumberland Md
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name REV. MELVIN J. GRIFFIN
13. Birthplace TEXAS

MOTHER
14. Maiden name MARION PEAVEY
15. Birthplace MASSACHUSETTES

16. Informant Memorial Hosp.
Address Cumberland Md

17. Burial (Burial, cremation, or removal, Which?) Date thereof Sept. 4, 1940 (month) (day) (year)

Cemetery or crematory Union Grove Cem.

Location Nr. Cumberland, Md.

18. Funeral director Harvey Zeigler
Address Hyndman Penna.

19. Sept. 4, 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH SEPTEMBER 3 1940, at 5:30 P.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19, to 19

and that I last saw h alive on 19

Immediate cause of death Anaemphalic Prostrosity

DURATION

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other

Address Date signed

DR. ENFIELD & TOPPER

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (170-C)

09227

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland, Maryland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? Fourteen days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No.: 807 Shriver Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** Isaac A. Hodel

**3.(b) Social Security Number:** 217-14-4655

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): Feb 6 - 1878

8. AGE: Years 62 | Months 7 | Days 12 | If less than one day ... hrs. ... min.

9. Birthplace: Md (Town, county, and state)

10. Usual occupation: Butcher

11. Industry or business: Retail Meat

FATHER
12. Name: Wm H. Hodel
13. Birthplace: Maryland

MOTHER
14. Maiden name: Barbara Mahon
15. Birthplace: Md

16. Informant: Mrs Geo. Zapler
Address: Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 21-40 (month) (day) (year)

Cemetery or crematory: St Patrick's Cem

Location: Cumberland Md

19. Funeral director: V. L. Lemperour
Address: Cumberland Md

19. 9/20/ 1940 (Date rec'd by registrar) Joseph C. Franklin M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: September 18, 1940, at 9:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 5, 1940, to Sept. 18, 1940 and that I last saw him alive on September 18, 1940

| Immediate cause of death | DURATION |
|---|---|
| Coronary Occlusion | Instantaneous |
| Due to: Contusion of back and left shoulder | 14 days |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Sept. 5, 1940

Where did injury occur? Cumberland, Allegany, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Automobile Injured at work?

23. SIGNATURE: B. W. Moler M.D. M. D. or other

Address: Cumberland, Maryland. Date signed: 9-20-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-F0

09228

## CERTIFICATE OF DEATH

Reg. Dist. No. 8

**1. PLACE OF DEATH:**

County: Allegany

City or town: Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 22 years

Hospital, Institution, or street address where death occurred: East Main Street

How long in hospital or institution? c

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants, give residence of mother)

State: Maryland County: Allegany

City or town: Lonaconing

(If outside city or town limits, write RURAL and give nearest town)

Street No.: East Main Street

(If rural, give LOCATION)

2.(a) If veteran, name war: c

**3.(a) FULL NAME:** Margaret Clydesdale Hoffa

**3.(b) Social Security Number:** c

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6.(b) Name of husband or wife: Charles Wm. Hoffa

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 18, 1869

8. AGE: Years 71 | Months 6 | Days 21 | If less than one day ..... hrs. ..... min.

9. Birthplace: Caldenbank Scotland (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER — 12. Name: James Young

FATHER — 13. Birthplace: Scotland

MOTHER — 14. Maiden name: Marion Paterson

MOTHER — 15. Birthplace: Scotland

16. Informant: Mrs. Wm. Rankin

Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 16, 1940 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg, Md.

18. Funeral director: W. E. Jackson

Address: Lonaconing, Md.

19. Sept 16 1940 (Date rec'd by registrar) E. O. Tyler Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 14 1940, at 9:00 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 4 1940, to September 14 1940

and that I last saw her alive on September 13 1940

| Immediate cause of death | DURATION |
|---|---|
| Primary Carcinoma of Gall Bladder. | |
| Due to | |
| Due to | |
| Other conditions: Metastatic Carcinoma of Liver. | |

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: .....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. M. Shelton Jr. M. D. or other

Address: Midland, Md. Date signed: Sept. 14, 1940

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 8 1940
BUREAU U. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09229

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Westernport

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 60 yrs.

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Westernport Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME:** Daniel Elmer Holler

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6 (b) Name of husband or wife: ALICE ALIDA STUBY Holler

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): October 29- 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 10 | 14 | hrs. min. |

9. Birthplace: Hyndman, Bedford, Penna.

(Town, county, and state)

10. Usual occupation: Retired Coal Miner

11. Industry or business

FATHER — 12. Name: Alex Holler

13. Birthplace: Penna

MOTHER — 14. Maiden name: Mary Gonder

15. Birthplace: Penna.

16. Informant: Albert Holler

Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 16-40 (month) (day) (year)

Cemetery or crematory: Philos Cemetery

Location: Westernport, Md.

18. Funeral director: W. H. Dredloak

Address: Piedmont, W. Va.

19. Sept. 16 19 40 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 13-1940 19 8:45 a.m. P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 19 40, to Sept 13 19 40, and that I last saw him alive on Sept. 13 19 40.

Immediate cause of death: Chronic myocarditis — DURATION: 1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: P. E. Berry M. D.

M. D. or other

Address: Piedmont W. Va. Date signed: 9/16/40

RECEIVED
OCT 5 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 115-E

09230

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

**1. PLACE OF DEATH:**

County Allegany

City or town Westernport
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Westernport
(If outside city or town limits, write RURAL and give nearest town)

Street No. 108 Waverly St.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Richard Leo Hott

**3. (b) Social Security Number** —

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife —

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 25, 1940

8. AGE: Years | Months 1 | Days 14 | If less than one day ... hrs. ... min.

9. Birthplace Keyser-Mineral-W. Va
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name Leo C. Hott
13. Birthplace Burlington, W. Va

MOTHER
14. Maiden name Pinkie E. Fair
15. Birthplace North Carolina

16. Informant Leo Hott
Address Westernport, Md.

17. Removal (Burial, cremation, or removal. Which?) Date thereof Sept 10, 1940 (month) (day) (year)

Cemetery or crematory

Location Akron, Ohio

18. Funeral director Ellsworth S. Boyd
Address Westernport Md.

19. Sept. 10 1940 (Date rec'd by registrar) A. J. Gaynbaker M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 1940 at 2 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept 3 1940, to Sept 9 1940 and that I last saw him alive on Sept 9 1940

| Immediate cause of death | DURATION |
|---|---|
| Capillary Bronchitis | 4 days |
| Due to | |
| Due to Septic Sore Throat | 6 " |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE P E Berry M.D. M. D. or other

Address Piedmont W. Va Date signed Sept 10. 1940

RECEIVED
OCT 5 1940
BUREAU V. S.

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09231

## CERTIFICATE OF DEATH

(8)

Reg. Dist. No. 6

**1. PLACE OF DEATH:**

County: Allegany

City or town: McCoole, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: McCoole, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME**

Baby Boy House

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

8.(b) Name of husband or wife

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Sept. 14, 1940

**8. AGE:** Years | Months | Days | If less than one day ..... hrs. ..... min.

Stillborn

9. Birthplace: McCoole, Md. Allegany Co.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Kenneth George House
13. Birthplace: ~~Rawlings, Md.~~ McCoole Md

MOTHER
14. Maiden name: Bessie Genevieve Iser
15. Birthplace: McCoole, Md.

18. Informant: George H. House
Address: McCoole Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sep 14 = 40 (month) (day) (year)

Cemetery or crematory: Dawson, Md

Location: Dawson, Md

18. Funeral director: Kenneth House
Address: McCoole, Md

19. Sept 14 1940 A. Baymbaker M.D.
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: September 14, 1940, at 1 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 14, 1940, to Sept. 14, 1940 and that I last saw ~~him~~ alive on dead Sep 14 1940

Immediate cause of death: Premature birth prolapse of cord — DURATION

Due to

Due to

Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: Raymond W. Reeves M.D.
M. D. or other

Address: Westernport Md Date signed: 9-14-40

RECEIVED
OCT 5 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (97)

## CERTIFICATE OF DEATH

09232

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution? MEMORIAL HOSPITAL 84 DAYS

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town CUMBERLAND, MARYLAND (If outside city or town limits, write RURAL and give nearest town)

Street No. 327 PENNA AVE (If rural, give LOCATION)

2.(a) If veteran, name war No.

**3. (a) FULL NAME** MR. MILTON L. HUFF

**3. (b) Social Security Number** 220-10-2580

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | MARRIED |

6.(b) Name of husband or wife MARGARET MESSENGER

6.(c) If alive, give age 67 years

7. Birth date of deceased (mo., day, yr.) NOVEMBER 4 1876

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 63 | 10 | 15 | ...hrs. ...min. |

9. Birthplace WEST VIRGINIA Town Alto (Town, county, and state)

10. Usual occupation W.P.A. WORKER

11. Industry or business Carpenter

FATHER 12. Name ABRAHAM D. HUFF (DECEASED)

13. Birthplace MARYLAND Sylviasport

MOTHER 14. Maiden name NANCY HARTZELL

15. Birthplace WEST VIRGINIA Terra Alta

16. Informant Margaret Huff

Address 327 Pa. Ave. Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 22, 1940 (month) (day) (year)

Cemetery or crematory Hill Crest

Location Cumberland Md

18. Funeral director Jacob Hafer

Address Cumberland

19. 9/23/ 19 40 (Date rec'd by registrar) Joseph C. Franklin (Registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH SEPTEMBER 19 1940 3:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 20, 1940, to Sept. 19, 1940 and that I last saw h... alive on Sept. 19, 1940

| Immediate cause of death | DURATION |
|---|---|
| Generalized Arteriosclerosis | 6/40 |
| Due to Uraemia caused | 9/1/40 |
| by the arteriosclerosis. Duration of | the |
| Due to latter is ten years. C.W.G.R. | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Mary E. Durrett M. D. or other

Address Cumberland Date signed Sept. 19, 1940.

DR. DURRETT

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

## CERTIFICATE OF DEATH

09233

Reg. Dist. No. 10

**1. PLACE OF DEATH:**

County: Allegany

City or town: Mount Savage – Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 28 years

~~Hospital, institution, or~~ street address where death occurred: above Calla Hill, Mount Savage.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Rural – Mount Savage

(If outside city or town limits, write RURAL and give nearest town)

Street No.: above Calla Hill

(If rural, give LOCATION)

2.(a) If veteran, name war:

**3.(a) FULL NAME:** Marietta Kaylor Hutzell

**3.(b) Social Security Number:**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| female | White | married |

6.(b) Name of husband ~~or wife~~: John Hutzell

6.(c) If alive, give age: 55 years

7. Birth date of deceased (mo., day, yr.): Sept. 24, 1884

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 55 | 11 | 17 | ...hrs. ...min. |

9. Birthplace: Morgan Co., West Virginia (Town, county, and state)

10. Usual occupation: housewife

11. Industry or business

FATHER 12. Name: Adam Kaylor

FATHER 13. Birthplace: West Virginia

MOTHER 14. Maiden name: Anna Eliza Largent

MOTHER 15. Birthplace: West Virginia

16. Informant: Husband and son

Address: Mount Savage

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 10 1940 (month) (day) (year)

Cemetery or crematory: Methodist Cemetery

Location: Mt Savage Md.

18. Funeral director: J. J. Durst

Address: Frostburg Md.

19. Sept 7 1940 (Date rec'd by registrar) H. J. Bostelle M.D. Local Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 7 1940, at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9:00 A.M., 9/7, 1940, to 1:45 P.M., 9/7, 1940

and that I last saw h...alive on 9/7 1940

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Hemorrhage | 5 hours + |
| Due to: General arteriosclerosis and Hypertension | unknown |
| Due to: | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op.: —

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: ... Injured at work?

23. SIGNATURE: William C. Harrison M.D. M. D. or other

Address: Mount Savage, Md. Date signed: 9/7/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

RECEIVED
OCT 3 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

09234

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs.

Hospital, institution, or street address where death occurred 611 Sylvan Ave.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 611 Sylvan Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** William H King

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6.(b) Name of husband or wife Catherine E. Mopley

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec 25 1853

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 86 | 9 | 1 | ..... hrs. ..... min. |

9. Birthplace Harrisburg Pa.
(Town, county, and state)

10. Usual occupation Cooper.

11. Industry or business Retired 1932

FATHER
12. Name Wm. King
13. Birthplace Unknown

MOTHER
14. Maiden name Elizabeth Burnback
15. Birthplace Unknown

16. Informant Wm R. E. King

Address Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 29 40 (month) (day) (year)

Cemetery or crematory Rose Hill Cem.

Location Cumberland.

18. Funeral director Louis Stein Inc

Address Cumberland.

19. Sept. 28 19 40 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Sept 26 1940 at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-19-40 19 , to 9-26 19 40 and that I last saw him alive on 9-11-40 19

Immediate cause of death Myocardial Degenation Cardiac Failure

DURATION ?

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Alfred Van Ormer M. D. or other

Address Cumberland, Md Date signed 9-27-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

09235

## CERTIFICATE OF DEATH

Reg. Diat. No. 7

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County Allegany

City or town Barton

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 82

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Md County Allegany

City or town Barton

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Janet Greenhoorn Kirk

**3. (b) Social Security Number**

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widow

B.(b) Name of husband or wife: James Kirk

B.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): July 25, 1858

8. AGE: Years 82 | Months 1 | Days 29 | If less than one day ..... hrs. ..... min.

9. Birthplace: Barton Allegany, Md (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Own home

FATHER

12. Name: John Greenhoorn

13. Birthplace: Scotland

MOTHER

14. Maiden name: Margaret Robertson

15. Birthplace: Scotland

16. Informant: John Kirk

Address: Barton Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 27, 1940 (month) (day) (year)

Cemetery or crematory: Laurel Hill Cem.

Location: Mosgrove, Md

18. Funeral director: D. J. Boal

Address: Barton, Md

19. Sept 25 1940 (Date rec'd by registrar) S. A. Boucher Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 24 1940 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1 1939, to Sept 24 1940

and that I last saw h=r alive on Sept. 1 1940

| | OURATION |
|---|---|
| Immediate cause of death: Chronic myocarditis | 2 yrs |
| Due to: arteriosclerosis | 5 yrs |
| Due to: | |
| Other conditions: Chronic cholecystitis | 5 yrs |

(Include pregnancy within 3 months of death)

Major findings of operations: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: P E Berry M.D.

M. D. or other

Address: Piedmont W. Va. Date signed 9/26/40

RECEIVED
OCT 5 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

09236

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 25 yrs.

Hospital, Institution, or street address where death occurred: 37 Virginia Ave.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 37 Virginia Ave
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Gertrude Ketzner

**3. (b) Social Security Number** None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: Hyland Ketzner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): May 14 1883

**8. AGE:** Years 57 Months 4 Days 3 If less than one day ..... hrs. ..... min.

9. Birthplace: Independence W. Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: John H Squires
13. Birthplace: W. Va.

MOTHER
14. Maiden name: Unknown
15. Birthplace

16. Informant: Hyland Ketzner
Address: Cumberland.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 21 '40 (month) (day) (year)

Cemetery or crematory: St Patricks Cem.

Location: Cumberland Md.

18. Funeral director: Louis Stein Inc.
Address: Cumberland.

19. 9/20/ 1940 (Date rec'd by registrar) Joseph P. Franklin M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 9/17/40 19..... at +A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2/24/39 19..... to 9/16/40 19.....
and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Carcinoma of breast

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations: Carcinoma of breast

Date of op. 2/24/39

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: John K Rozner MD M. D. or other

Address: Cumberland Md. Date signed 9/17/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (133-C)

09237

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Memorial Hospital
Stay in hospital or inst. (yrs., or mos., or days): 1 day
Stay in this community (yrs., or mos., or days): 13 yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Md Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: Valley Road Rd # 3
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Virginia Etta Knapp

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F. | W | Child |

B (b) Name of husband or wife:
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): June 22, 1927

8. AGE: Years: 13 Months: 3 Days: 1 If less than one day: hrs. min.

9. Birthplace: Cumberland, Allegany, Md.
(Town, county, and state)

10. Usual occupation: Student

11. Industry or business: School

FATHER
12. Name: Col Edgar Knapp
13. Birthplace: Dundon, W. Va.

MOTHER
14. Maiden name: Sylvia Hook
15. Birthplace: Champwill Pennsylvania

16. Informant: Mrs. Sylvia Knapp
Address: Valley Road Cumberland Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Sept 25, 1940
(month) (day) (year)
Cemetery or crematory: Fairview Cemetery
Location: Fairview Penna

18. Funeral director: Jacob Hafer
Address: Cemberland, Md

19. Sept. 25 1940 (Date rec'd by registrar) Joseph C. Franklin Registrar M.D.

Van

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 23 1940, at 8 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-20-40 19 to 9-23-40 19, and that I last saw h alive on 9-22-40 19

| Immediate cause of death | DURATION |
|---|---|
| Nephrosis following | |
| Due to resect of peritonitis. | 3 years |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W. alfred Van Dam
M. D. or other
Address: Cumberland, Md Date signed: 9-24-40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (T)

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

09238

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Windsor Hotel
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. Windsor Hotel
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Charles E. Koons

**3.(b) Social Security Number** 214-05-7331

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | White | married |

6.(b) Name of husband or wife May Crull
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) June 15, 1882

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 58 | 3 | 0 | ..... hrs. ..... min. |

9. Birthplace Harrisburg Pa.
(Town, county, and state)
10. Usual occupation Clerk
11. Industry or business Hotel
FATHER 12. Name Jacob L. Koons
13. Birthplace Pa.
MOTHER 14. Maiden name Tillie Eyster
15. Birthplace Pa.
16. Informant May Crull
Address Windsor Hotel
17. Removal Date thereof Sept. 17 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Camp Hill Cemetery
Location Harrisburg Pa.
18. Funeral director Louis Stein Inc.
Address Cumberland, Md.
19. 9/16/ 19 40 Joseph C. Franklin Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION**

20. DATE OF DEATH 9-15-40 19 9:30 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-14-40 19 to 9-15-40 19
and that I last saw h... alive on 9-14-40 19

| Immediate cause of death | DURATION |
|---|---|
| Coronary Occlusion | 1 day |
| Due to 2 | |
| Due to 2 | |
| Other conditions Bronchial Asthma | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE [signature] M. D. or other
Address [signature] Date signed 9-16-40

M.D.

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 7 19[illegible]
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (19)

## CERTIFICATE OF DEATH

09239

Reg. Diat. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
Allegany Hospital
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md County Allegany
City or town Cumberland Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 17 - 5th St
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME** Baby Boy Landis,

**3.(b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | White | Single |

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 30, 1940

8. AGE: Years | Months | Days | If less than one day: 2 hrs. min.

9. Birthplace Cumberland Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER
12. Name Emory C. Landis
13. Birthplace Petersburg W Va

MOTHER
14. Maiden name Pearl Evans
15. Birthplace Petersburg, West Va.

16. Informant Mr. Emory C. Landis
Address Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 5 40 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Cumberland, Md.

18. Funeral director Louis Stein Inc
Address Cumberland, Md.

19. Oct. 5 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Sept. 30 1940 at 3:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19.. to ..... 19..
and that I last saw h.. alive on Sept 30 19..

| Immediate cause of death | DURATION |
|---|---|
| Prematurity | |
| Due to 5 month gestation | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W B Barrow M.D.
M. D. or other
Address 122 Bedford St Date signed 9/30/40

RECEIVED
OCT 7 1940
BUREAU V. S

09240

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-a)

## CERTIFICATE OF DEATH

Reg. Dist. No. 10

**1. PLACE OF DEATH:**

County: Allegany

City or town: Mt Savage (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 58 yrs.

Hospital, institution, or street address where death occurred: Old Row

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Mt Savage (If outside city or town limits, write RURAL and give nearest town)

Street No.: Old Row (If rural, give LOCATION)

2.(a) If veteran, name war

**3.(a) FULL NAME:** Catherine Regina Lemmert

**3.(b) Social Security Number**

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Married

6.(b) Name of husband or wife: John Lemmert

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): June 16 1882

**8. AGE:** Years 58 | Months 3 | Days 9 | If less than one day ..... hrs. ..... min.

8. Birthplace: Mt Savage Md. (Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: At Home.

FATHER
12. Name: Chas C Smith
13. Birthplace: Germany.

MOTHER
14. Maiden name: Catherine Lynch
15. Birthplace: Md.

16. Informant: John Lemmert

Address: Mt Savage

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 27 1940 (month) (day) (year)

Cemetery or crematory: Episcopal Cem.

Location: Mt Savage Md.

18. Funeral director: Louis Stein Inc.

Address: Cumberland Md.

19. Oct 2 Sept 1940 (Date rec'd by registrar) H. J. Bostetter M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Sept 25 1940, at 1 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1940 to Sept 25 1940 and that I last saw her alive on Sept 20 1940

Immediate cause of death: Chronic nephritis Hypertension — DURATION: 1 year

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ..... Injured at work?

23. SIGNATURE: W. M. Lane Jr. M.D. (M. D. or other)

Address: Frostburg Md. Date signed: Oct 1 1940

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

CEIVED
OCT 3 1940
U. S.

09241

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

WITHIN CORPORATE LIMITS

# CERTIFICATE OF DEATH

Reg. Dist. No. 9

**1. PLACE OF DEATH:**

County Allegany County

City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 years

Hospital, Institution, or street address where death occurred: 103 W. Main St (Home)

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No. 103 W Main
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Elizabeth Steele Lemmert

**3. (b) Social Security Number** — none

4. Sex: Female

5. Color or race: white

6.(a) Single, married, widowed, or divorced: widowed

6.(b) Name of husband or wife: John Adam Lemmert

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Feb. 15 - 1863

8. AGE: Years 77 | Months 6 | Days 26 | If less than one day ..... hrs. ..... min.

9. Birthplace: Bedford County Penna
(Town, county, and state)

10. Usual occupation: home maker

11. Industry or business

FATHER
12. Name: Jacob Steele
13. Birthplace: Germany

MOTHER
14. Maiden name: Catherine Froelich
15. Birthplace: Germany

16. Informant: Harrison E. Lemmert

Address: 28 Beall Lane Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 15 1940 (month) (day) (year)

Cemetery or crematory: Allegany Cemetery

Location: Frostburg Md.

18. Funeral director: Jacob Nafer

Address: Frostburg Md.

19. Sept. 14 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 13 1940, at 4:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov 30 1939 to Sept 13 1940 and that I last saw her alive on Sept 12 1940

Immediate cause of death: Chronic Myocarditis — DURATION: 1 yr.

Due to

Due to

Other conditions: Thrombo-Phlebitis Rt. Leg — 1 Day
(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: W. D. McLane Jr. M.D.
M. D. or other

Address: Frostburg Md. Date signed 9-13-40

VS A15 (T)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 2 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

09242

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15 (T)

**1. PLACE OF DEATH:**
County Allegany
City or town Westernport
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Poplar St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 6 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Westernport Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Poplar
(If rural give LOCATION)
2(c) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Ralph Seymour Lemmon

**3. (b) Social Security Number** 214-12-3229

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Married
6 (b) Name of husband or wife: Gladys DeWitt Lemmon
6(c) If alive, give age: 48 years
7. Birth date of deceased (mo., day, yr.): Jan. 15, 1891
8. AGE: Years 49 | Months 8 | Days 9 | If less than one day: hrs. min.
9. Birthplace: Wheeling, Ohio, W. Va.
(Town, county, and state)
10. Usual occupation: Carpenter
11. Industry or business: W.P.A. Project
FATHER 12. Name: Eugene Lemmon
13. Birthplace: Wheeling, W. Va.
MOTHER 14. Maiden name: Hannah Valet
15. Birthplace: Wheeling, W. Va.
16. Informant: Mrs. Ralph S. Lemmon
Address: Poplar St. Westernport, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 27, 1940 (month) (day) (year)
Cemetery or crematory: Philos
Location: Westernport, Md.
18. Funeral director: D. J. Healy
Address: Barton, Md.
19. Sept. 26 1940 (Date rec'd by registrar) J. Bazinbaker M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Sept. 24, 1940, at 7:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 24 1940, to Sept 24 1940, and that I last saw him alive on Sept. 24 1940.

| Immediate cause of death | DURATION |
|---|---|
| Coronary Embolus | 1 Hour |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Ot operations
Ot autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: None
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE Paul R. Wilson, M.D.
M. D. or other
Address Piedmont, W. Va. Date signed 9-26-40

RECEIVED
OCT 5 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

## CERTIFICATE OF DEATH

09243

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 13 years
Hospital, institution, or street address where death occurred:
Found dead near Gay St. (Silk Mill property)
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 248 N Centre St
(If rural, give LOCATION)
2.(a) If veteran, name war World War

**3.(a) FULL NAME** James Ray Lewis

**3.(b) Social Security Number** 220-10-8761

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6.(b) Name of husband or wife Carrie Mullen Lewis
6.(c) If alive, give age 38 years

7. Birth date of deceased (mo., day, yr.) Aug 8, 1902

8. AGE: Years 38 | Months | Days 24 | If less than one day ..... hrs. ..... min.

9. Birthplace Cumberland, Md
(Town, county and state)

10. Usual occupation Pipe fitter

11. Industry or business Rail Road

FATHER
12. Name Ward Lewis
13. Birthplace Martinsburg W. Va.

MOTHER
14. Maiden name Jenkins
15. Birthplace Martinsburg W. Va.

16. Informant Carrie Lewis
Address Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 4, 1940 (month) (day) (year)
Cemetery or crematory St Peters & Paul's
Location Cumberland Md

19. Funeral director Jacob Hafer
Address Cumberland

18. Sept 3 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 1st., 1940 About 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....
and that I last saw h..... alive on ..... 19.....

| | DURATION |
|---|---|
| Immediate cause of death Coronary Thrombosis | |
| | |
| Due to | |
| | |
| Due to | |
| | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations .....
Date of op. .....
Autopsy results none
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE Pierce H. Bouse, M.B.
M. D. or other
Address Cumberland, Maryland Date signed 9/3/40

Deputy Medical Examiner - Allegany Co.

RECEIVED
SEP 9 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (K9)

09244

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

**1. PLACE OF DEATH:**

County: Allegany County

City or town: Cumberland, Maryland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 10 yrs

Hospital, institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 7 hrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 212 Avirett Ave., City (If rural, give LOCATION)

2.(a) If veteran, name war:

3.(a) FULL NAME: WILLIAM JOHN MACDONALD

3.(b) Social Security Number: 705-07-9532

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6.(b) Name of husband or wife: None

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): July 7, 1904

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 36 | 2 | 22 | hrs. min. |

9. Birthplace: West Virginia (Town, county, and state)

10. Usual occupation: Brakeman

11. Industry or business: BALTIMORE & OHIO R.R.

FATHER 12. Name: William Z. MacDonald

FATHER 13. Birthplace: West Virginia

MOTHER 14. Maiden name: Sena Haslacker

MOTHER 15. Birthplace: West Virginia

16. Informant: Memorial Hospital

Address: Cumberland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct 2 '40 (month) (day) (year)

Cemetery or crematory: Queens Point Cem.

Location: Keyser W. Va.

18. Funeral director: Louis Stein Inc.

Address: Cumberland

19. Oct. 2 1940 (Date rec'd by registrar) J. P. Franklin M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 29, 1940 at 5:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 29, 1940 to Sept. 29, 1940 and that I last saw him alive on September 29, 1940

| Immediate cause of death | DURATION |
|---|---|
| Shock | 2 hrs. |
| Due to: Fractures of several lumbar vertebrae and multiple | |
| Due to: fractures of the pelvis. | 2 hrs. |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Accident Date of: Sept. 29, 1940

Where did injury occur? Cumberland, Allegany, Md. (City or town) (County) (State)

Injured at home, farm, industry, public place (where?): B. & O. Railroad

Means of injury: Crushed between two railroad cars. Injured at work? Yes

23. SIGNATURE: W. H. Moler M. D. or other

Address: Cumberland, Maryland Date signed: 9-30-40

DR. MOLER

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

09245

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(S)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMERLAND (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: MEMORIAL HOSPITAL

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State W. VA. County PRESTON

City or town TERRA ALTA, W. VA. (If outside city or town limits, write RURAL and give nearest town)

Street No. (If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** BABY BOY MARKWOOD

**3. (b) Social Security Number**

4. Sex: MALE

5. Color or race: WHITE

6.(a) Single, married, widowed, or divorced

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPTEMBER 22, 1940

8. AGE: Years | Months | Days | If less than one day STILLBORN hrs. min.

9. Birthplace CUMBERLAND, MARYLAND, ALLEGANY CO. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER: 12. Name WILLIAM MARKWOOD

13. Birthplace W. VA.

MOTHER: 14. Maiden name VIRGINIA CASTEEL

15. Birthplace PA.

16. Informant WILLIAM MARKWOOD

Address TERRA ALTA, W. VA.

17. Cremation (Burial, cremation, or removal, Which?) Date thereof Sept. 22, 1940 (month) (day) (year)

Cemetery or crematory Destroyed

Location at

18. Funeral director Hospital

Address

19. Sept. 28 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 22, 1940, at 11:45 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 22 1940, to Sept 22 1940 and that I last saw h. 1.127 alive on Stillborn 19

Immediate cause of death: Prematurity (3 mo. gestation)

Due to Induced abortion (Therapeutic)

Due to

Other conditions

(Include pregnancy within 8 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur F. Jones M.D. M. D. or other

Address 40 N. Liberty St. Date signed 9-27-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 7 1940
BUREAU V. S.

09246

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-01)

## CERTIFICATE OF DEATH

Reg. Dist. No. 8

**1. PLACE OF DEATH:**

County: Allegany

City or town: Midland (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Back Street

Stay in hospital or insf. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 41 yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Midland Ward No.: (If outside city or town limits, write RURAL NEAR and give town)

Street No.: Back Street (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

**3. (a) FULL NAME:** Jesse Dolan Marshall

**3. (b) Social Security Number:** —

4. Sex: Male

5. Color or race: White

6. (a) Single, married, widowed, or divorced: Married

6 (b) Name of husband or wife: Susan M. Snyder Marshall

6 (c) If alive, give age: 75 years

7. Birth date of deceased (mo., day, yr.): June 26, 1864

**8. AGE:** Years: 76 Months: 2 Days: 15 If less than one day: hrs. min.

9. Birthplace: Doman, Hardy County, W. Va. (Town, county, and state)

10. Usual occupation: Merchant - (Retired)

11. Industry or business: Own Store

FATHER
12. Name: Marshall
13. Birthplace: Unknown

MOTHER
14. Maiden name: Unknown
15. Birthplace: Unknown

16. Informant: Mrs. Joseph Jones

Address: Midland, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 13 1940 (month) (day) (year)

Cemetery or crematory: Ashbury Church Cemetery

Location: Doman, W. Va

18. Funeral director: M. Eickhorn

Address: Lonaconing, Md.

19. Sept 12 1940 (Date rec'd by registrar) E. Ross Tyler Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 11 1940, at 10 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 3 1940, to Sept. 11 1940, and that I last saw him alive on Sept. 10 1940.

Immediate cause of death: Cerebral Hemorrhage

Due to: Hypertension

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

DURATION

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: R M Shelton Jr. M. D. ~~or other~~

Address: Midland, Md. Date signed: 9-12-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

09247

## CERTIFICATE OF DEATH.

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town ~~Mar~~ Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days) 3 days

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 329 Fredrick St.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Carrie "Frisby" Martin

**3. (b) Social Security Number** 217-10-6843

4. Sex F.

5. Color or race Colored

6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife John Martin

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) April 28, 1896

8. AGE: Years 44 Months 7 Days 14 If less than one day ____ hrs. ____ min.

9. Birthplace Westminster, Carroll Co, Md.
(Town, county, and state)

10. Usual occupation Cook

11. Industry or business Restaurant

FATHER
12. Name Samuel Frisby
13. Birthplace Westminster Md.

MOTHER
14. Maiden name Rebecca Bowen
15. Birthplace Westminster, Md.

16. Informant Harry Frisby
Address 36 N. Water St - Frostburg Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 15, 1940 (month) (day) (year)

Cemetery or crematory Allegany

Location Frostburg, Md.

18. Funeral director Jacob Hafer
Address Cumberland, Md.

19. 9/13/ 1940 (Date rec'd by registrar) J. P. Franklin Registrar M.D.

Holloman

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12 1940, at 12 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 4th 1940, to Sept. 12 1940, and that I last saw her alive on Sept. 11th 1940.

Immediate cause of death Diabetic Millicus

DURATION unknown

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations none

Of autopsy none

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: 200

Accident, suicide, or homicide — Date of

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE J. P. Langton M. D. or other

Address 54 N. Mark St. Date signed 9-13-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

09248

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

(107)

Reg. Dist. No. 7

**1. PLACE OF DEATH:**

County Allegany

City or town Easton
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 5-4 years

Hospital, Institution, or street address where death occurred

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md. County Allegany

City or town Baston
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Mary Lamond Maybray

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6.(b) Name of husband or wife John Maybray

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) April 30, 1866

8. AGE: Years 74 | Months 4 | Days 12 | If less than one day ..... hrs. ..... min.

9. Birthplace Pekin, Allegany, Md.
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business Own home

FATHER 12. Name John D. Reynolds

13. Birthplace Scotland

MOTHER 14. Maiden name Catherine Mackey

15. Birthplace Scotland

16. Informant Maud Maybray

Address Baston, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 15 1940 (month) (day) (year)

Cemetery or crematory Laurel Hill

Location Moscow, Md.

18. Funeral director D. D. Boal

Address Baston, Md.

19. Sept 13 1940 (Date rec'd by registrar) S. A. Boucher Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 12, 1940 at 1:45 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 1940 to Sept 12 1940 and that I last saw her alive on Sept 12 1940

| Immediate cause of death | DURATION |
|---|---|
| Hypostatic Pneumonia | 2 days |
| Bronchial Pneumonia Due to: Contributory | 2 weeks |
| Due to Confined to Bed | |
| Due to | |
| Other conditions Sacro-Iliac Strain | 2 months |

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op.

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: No

Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury Injured at work?

23. SIGNATURE P E Berry M D
M. D. or other

Address Piedmont W. Va. Date signed 9/14/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 5 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (8)

## CERTIFICATE OF DEATH

09249

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 228 Glenn, St

(If rural give LOCATION)

2(c) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Baby Boy May

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September 30 1940

8. AGE: Years | Months | Days | If less than one day hrs. min.

9. Birthplace Gilbert Cumberland, Md (Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Weston Lewester May

13. Birthplace Timberridge, W Va

MOTHER 14. Maiden name Lillian Agnes Sager

15. Birthplace Cumberland Md.

16. Informant Mr. Weston May

Address 228 Glenn St. City

17. Burial (Burial, cremation, or removal. Which?) Date thereof Oct. 1, 1940 (month) (day) (year)

Cemetery or crematory St. Peters and Paul Cem

Location Cumberland, Md

18. Funeral director Jacob Sager

Address Cumberland, Md

19. Oct. 1 19 40 J. L. Franklin, M.D. (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Sept. 30 1940, at 3:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 30 1940, to Sept. 30 1940, and that I last saw him alive on Sept. 30 1940

Immediate cause of death Difficult Labor — DURATION 3 hours

Due to

Due to

Other conditions Premature 2 1/2 weeks

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W Royce Hodges, M.D. M. D. or other

Address Cumberland Md Date signed 10/1/40

RECEIVED
OCT 7 1940
BUREAU V. S.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

09250

## CERTIFICATE OF DEATH

Reg. Dist. No. 6

**1. PLACE OF DEATH:**

County Allegany

City or town Westernport, Md (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: 216 Rock St.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State Md. County Allegany

City or town Westernport (If outside city or town limits, write RURAL and give nearest town)

Street No. 216 Rock. (If rural, give LOCATION)

2.(a) If veteran, name war

3.(a) FULL NAME "Baby" Boy Mayler

3.(b) Social Security Number

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Single

6.(b) Name of husband or wife: —

6.(c) If alive, give age ... years

7. Birth date of deceased (mo., day, yr.): Sept 29, 1940

8. AGE: Years | Months | Days | If less than one day: 1 hrs. ... min.

9. Birthplace: Westernport - Allegany - Md. (Town, county, and state)

10. Usual occupation: —

11. Industry or business

FATHER
12. Name: William Mayler
13. Birthplace: Henry - W. Va

MOTHER
14. Maiden name: Evelyn Ahern
15. Birthplace: Westernport, Md.

16. Informant: William Mayler

Address: Westernport, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 30/1940 (month) (day) (year)

Cemetery or crematory: Philos

Location: Westernport, Md.

18. Funeral director: Ellsworth S. Boal

Address: Westernport, Md.

19. Sept. 30 1940 (Date rec'd by registrar) A. Barnbaker M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1940 at 4 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 29 1940, to Sept 29 1940 and that I last saw h.? alive on Sept 29 1940

Immediate cause of death: Premature — DURATION: 7 mo.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations: —

Date of op. —

Autopsy results: —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work?

23. SIGNATURE: P. E. Berry M.D. M. D. or other

Address: Piedmont W. Va. Date signed 9/30/40

RECEIVED
OCT 5 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95-C

09251

## CERTIFICATE OF DEATH

Reg. Dist. No. 9

**1. PLACE OF DEATH:**
County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 35 years
Hospital, Institution, or street address where death occurred: 160 Maple Street
How long in hospital or institution? —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)
Street No.: 160 Maple Street
(If rural, give LOCATION)
2.(a) If veteran, name war: none

**3.(a) FULL NAME:** Joseph Wm. McAtee

**3.(b) Social Security Number:** none

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Margaret McDonald McAtee
6.(c) If alive, give age: 60 years

7. Birth date of deceased (mo., day, yr.): Nov 13/1887

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 ~~52~~ | 10 | 0 | ..... hrs. ..... min. |

9. Birthplace: Mt. Lessport, Allegheny Co., Pa.
(Town, county, and state)
10. Usual occupation: Professional Artist
11. Industry or business: Own
FATHER 12. Name: Joseph McAtee
13. Birthplace: Mt. Savage, Md
MOTHER 14. Maiden name: Unknown
15. Birthplace: "
18. Informant: Mrs. Margaret McAtee
Address: Frostburg, Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 16/1940 (month) (day) (year)
Cemetery or crematory: St. Michaels Cemetery
Location: Frostburg, Md
18. Funeral director: M. Eichhorn
Address: Lonaconing, Md
19. Sept. 15 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 13 1940 at 4 45 p M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 13, 1940 to SEPT. 13 1940 and that I last saw h. alive DEAD on SEPT. 13 1940

| Immediate cause of death | DURATION |
|---|---|
| Acute Cardiac failure | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Glen Kilday M. D.
M. D. or other
Address: Frostburg, Md Date signed: 9/13/40

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 2 1940
BUREAU V. S.

Outside of ~~corporate limits~~ City Limits

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

## CERTIFICATE OF DEATH

09252

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County ALLEGANY
City or town ROBERTS PLACE
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Near Cumberland
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 15 YRS

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State ALLEGANY County Md.
City or town ROBERTS PLACE Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** JAMES ELMER McCLELLAN

**3. (b) Social Security Number** Unknown

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | White | WIDOWER |

6 (b) Name of ~~husband~~ or wife ELLEN ROGERS

DECEASED 6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) JUNE 5 - 1864

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 76 | 3 | 24 | hrs. min. |

9. Birthplace West Va. (Town, county, and state)

10. Usual occupation R.R. TRACKMAN

11. Industry or business

FATHER
12. Name WM McCLELLAN
13. Birthplace Scotland.

MOTHER
14. Maiden name SARAH SPARKS
15. Birthplace Scotland.

16. Informant MRS Ethel GARDINER DAUGHTER
Address Roberts Pl.

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof Oct 1, 1940 (month) (day) (year)
Cemetery or crematory OAK HILL CEM.
Location LONACONING Md.

18. Funeral director O.L. Lemperenr
Address 202 Green St. Cumbd Md.

19. Oct. 1 (Date rec'd by registrar) 19 40 J.P. Franklin M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 29 1940, at A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 25 1940 to Sept. 27 1940, and that I last saw ~~him~~ alive on Sept 27 1940

| Immediate cause of death | DURATION |
|---|---|
| Chronic Myocarditis | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W B Barnum M. D. or other
Address 122 Bedford St Date signed 10/1/40

Please give this to Dr. Barrow

T. L. Lemperem

will call back this morning

RECEIVED
OCT 7 1940
BUREAU V. S

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (95-C)

## CERTIFICATE OF DEATH

09253

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, ~~hospital, or institution~~: 45 Green St

Stay in hospital or inst. (yrs., or mos., or days) —

Stay in this community (yrs., or mos., or days) 40 yrs

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 45 Green

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR —

**3. (a) FULL NAME** Henry W. Miller

**3. (b) Social Security Number** none

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6 (b) Name of husband or wife Mary Mean

6(c) If alive, give age 72 years

7. Birth date of deceased (mo., day, yr.) March 6 - 1866

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 74 | 6 | 2 | ____ hrs. ____ min. |

9. Birthplace Maryland (Town, county, and state)

10. Usual occupation Miner

11. Industry or business Coal

FATHER — 12. Name Joseph Miller

13. Birthplace England

MOTHER — 14. Maiden name Catherine Mean

15. Birthplace Maryland

16. Informant Mrs Mary Miller

Address Cumberland, Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 7-40 (month) (day) (year)

Cemetery or crematory Catholic Cemetery

Location Lonaconing, Md.

18. Funeral director U. L. Leatherwood

Address Cumberland, Md.

19. Sept. 7 19 40 J. L. Franklin, M. D. (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH September 4 19 40, at 10:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 35 to Sept 4 19 40, and that I last saw him alive on Sept 4 19 40.

| | DURATION |
|---|---|
| Immediate cause of death: Hypertention acute dilation of heart | 8 yrs 6 hrs |
| Due to — | |
| Due to — | |
| Other conditions — | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations —

Of autopsy —

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Cyrus R. Everhart M.D. M. D. or other

Address 36 Greene St, Cumberland, Md. Date signed

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(2)

# CERTIFICATE OF DEATH

092549

Reg. Dist. No.

**1. PLACE OF DEATH:**

County: Allegany

City or town: Frostburg, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: Miners Hosp.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Baby Mire

**3. (b) Social Security Number** None

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced

B.(b) Name of husband or wife

~~Sept 24~~ B.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 24, 1940.

8. AGE: Years | Months | Days | If less than one day: Stillborn hrs. min.

9. Birthplace: Frostburg Md.
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER
12. Name: Michael Mire
13. Birthplace: Syria

MOTHER
14. Maiden name: Beddie Sangid
15. Birthplace: Syria

16. Informant: Michael Mire
Address: Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept-24-1940 (month) (day) (year)

Cemetery or crematory: Home Place

Location: Frostburg Md. (Water St)

18. Funeral director: Michael Cassen Mire

Address: Water St. Frostburg, Md.

19. Sept. 24 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 24 1940 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

Immediate cause of death: Stillborn

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

DURATION

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: N. E. Gatters M.D. M. D. or other

Address: Frostburg, Md. Date signed: 9/24/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 2 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

## CERTIFICATE OF DEATH

09255

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Moscow Rural (Barton P.O.)
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution:

Stay in hospital or inst. (yrs., or mos., or days):

Stay in this community (yrs., or mos., or days): 78 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Moscow Md. Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Sarah Elizabeth Cook Myers

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband or wife: Mont Myers

6(c) If alive, give age: 77 years

7. Birth date of deceased (mo., day, yr.): Dec. 21, 1862

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 77 | 8 | 11 | hrs. min. |

9. Birthplace: Niles, Ohio
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: Own home

FATHER
12. Name: William Cook
13. Birthplace: England

MOTHER
14. Maiden name: Clara Lee
15. Birthplace: England

16. Informant: Mr. Mont Myers

Address: Moscow, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 4 1940 (month) (day) (year)

Cemetery or crematory: Laurel Hill - Sept 4, 1940

Location: Moscow Md.

18. Funeral director: D. S. Boaly

Address: Barton, Md.

19. Sept. 3 1940 (Date rec'd by registrar) S. A. Boucher Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 1 1940, at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1940, to Sept 1 1940, and that I last saw h-er alive on Sept 1 - 40 19

| Immediate cause of death | DURATION |
|---|---|
| Coronary Thrombosis | 1 day |
| Due to | |
| Due to | |
| Other conditions: Hypertension — arteriosclerosis — old age | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: R. W. Keener M.D.
M. D. or other

Address: Westernport, Md. Date signed: 9-4-40

RECEIVED
OCT 5 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

09256

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (92-d)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND MARYLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 2 DAYS

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State MARYLAND County GARRETT

City or town KITZMILLER
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME**
MR. GEORGE NEWARK

**3. (b) Social Security Number**
None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | Unknown |

6.(b) Name of husband or wife

6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Dont Know

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | | | hrs. min. |

9. Birthplace YUGOSLAVIA
(Town, county, and state)

10. Usual occupation MINER

11. Industry or business

FATHER
12. Name Dont Know
13. Birthplace Dont Know

MOTHER
14. Maiden name Dont Know
15. Birthplace Dont Know

16. Informant O. F. Sharpless
Address Blaine WVa

17. Removal Date thereof Sept 28/40
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Kalbaugh Cemetery

Location Elk Garden WVa

18. Funeral director O. F. Sharpless
Address Blaine WVa

19. 9/27/ 1940 Joseph P. Franklin M.D. Registrar
(Date rec'd by registrar)

**MEDICAL CERTIFICATION** 3:30 P.M

20. DATE OF DEATH SEPTEMBER 25 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 23 1940, to September 25 1940 and that I last saw him alive on September 25 1940

| Immediate cause of death | DURATION |
|---|---|
| Chronic Myocarditis | 2 yr ovs |
| Due to Chronic endocarditis | 1 year |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [signature] M.D.
M. D. or other

Address Cumberland Md. Date signed 9/26/40

DR. LANICH & BROADRUP

VS A15 I MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4 — 09257

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? Sept. - 1940

Hospital, institution or street address where death occurred: Memorial Hosp.

How long in hospital or institution? none

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 451 Henderson Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war:

**3.(a) FULL NAME:** Charles E. Nordquist

**3.(b) Social Security Number:** 705-12-0053

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Divorced |

6.(b) Name of husband or wife: Not Known

6.(c) If alive, give age: ..... years

7. Birth date of deceased (mo., day, yr.): July 26 - 1881

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 59 | 1 | 18 | ..... hrs. ..... min. |

9. Birthplace: Sweden
(Town, county, and state)

10. Usual occupation: B & O. Employee

11. Industry or business: Crossing Watchman

12. Name of father: Erick Nordquist

13. Birthplace of father: Sweden

14. Maiden name of mother: Christine Johnson

15. Birthplace of mother: Sweden

16. Informant: Eugene E. Nordquist Jr.

Address: Detroit Michigan

17. Disposal (Burial, cremation, or removal? Which?): Removal

Date thereof: Sept 17, 1940 (month) (day) (year)

Cemetery or crematory: Jefferson Memorial Cemetery

Location: Pittsburgh, Pa.

19. Funeral director: J. A. Henderson

Address: Cumberland Md.

19. 9/17/ 19 40 (Date rec'd by registrar)

J. A. Franklin Registrar
M. D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 14th., 19 40, at about 5 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ..... 19..... to ..... 19.....

and that I last saw h..... alive on ..... 19.....

| Immediate cause of death | DURATION |
|---|---|
| Coronary Occlusion | |
| | |
| Due to | |
| | |
| Due to | |
| | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: .....

Date of op. .....

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: Phineas H. Borden, M. D.
M. D. or other

Address: Cumberland, Maryland Date signed: 9/14/40

Deputy Medical Examiner - Allegany Co.

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (137-C)

09258

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 62 yrs.

Hospital, institution, or street address where death occurred: Allegany Hospital

How long in hospital or institution? 7 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)

Street No. 884 Sperry Terrace (If rural, give LOCATION)

2.(a) If veteran, name war: Spanish American War.

**3. (a) FULL NAME:** Charles C. Ogletay

**3. (b) Social Security Number:** 705-09-9645

4. Sex: Male

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Margaret Wagner

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): Oct 31, 1877

**8. AGE:** Years: 62 Months: 10 Days: 3 If less than one day ..... hrs. ..... min.

9. Birthplace: Cumberland Md. (Town, county, and state)

10. Usual occupation: Car Repairer

11. Industry or business: B & O Ry.

FATHER: 12. Name: Howard Ogletay

13. Birthplace: Md

MOTHER: 14. Maiden name: Lucy Fisher

15. Birthplace: Md.

16. Informant: Chas. A. Ogletay

Address: Cumberland

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 6 40 (month) (day) (year)

Cemetery or crematory: Greenmont Cem.

Location: Cumberland Md.

18. Funeral director: Louis Stein Inc

Address: Cumberland Md.

19. Sept 5 1940 (Date rec'd by registrar) Joseph P. Franklin Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Sept 3 1940 at 1:45 P.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Aug 23 1940 to Sept 3 1940 and that I last saw him alive on Sept 3 1940

Immediate cause of death: Peritonitis — DURATION: 8 or 10 days?

Due to: Extention from pelvic abscess

Due to:

Other conditions: Pelvic abscess from rupture prostatic abscess — 2 weeks?

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....

Autopsy results: Same as above.

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work?

23. SIGNATURE: R. W. Trevaskis M. D. or other

Address: Cumberland, Md Date signed: Sept 4-40

VS A15 (T)

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECE
SEP 21 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

09259

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-6)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 83 yrs.

Hospital, institution, or street address where death occurred: 233 Averitt Ave.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany.

City or town Cumberland.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 233 Averitt Ave.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Mary Ann O'Neill.

**3. (b) Social Security Number** None

4. Sex: Female

5. Color or race: White

6.(a) Single, married, widowed, or divorced: Widowed

6.(b) Name of husband or wife: Edward O'Neill

6.(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.): Mar 8. 1857

**8. AGE:** Years 83 | Months 6 | Days 10 | If less than one day ..... hrs. ..... min.

9. Birthplace: Cumberland Md.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business: at Home.

FATHER
12. Name: Patrick Kean
13. Birthplace: Ireland.

MOTHER
14. Maiden name: Mary Mulligan
15. Birthplace: Ireland.

16. Informant: Ed. O'Neill
Address: Cumberland Md.

17. S.B. Burial 40 (Burial, cremation, or removal, which?) Date thereof: Sept 21 40 (month) (day) (year)

Cemetery or crematory: St. Patricks Cem.

Location: Cumberland.

18. Funeral director: Louis Stein Inc.
Address: Cumberland.

19. 9/20/ 19 40 (Date rec'd by registrar) Joseph P. Franklin M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Sept. 18 1940, at 11 P M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept. 10 1940, to Sept. 18 1940 and that I last saw her alive on Sept 18 1940

| Immediate cause of death | DURATION |
|---|---|
| Chronic Myocarditis | 1937 |
| Chronic Nephritis | 1937 |
| Due to Arteriosclerosis | 1935 |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: NO

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: A. W. Gleason M.D. M.D. or other

Address: 126 Union St. Cumberland Md. Date signed 9/19/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

09260

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

(47-C)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
Clement Street

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. Clement Street
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME**
Jacob Daniel Piper

**3. (b) Social Security Number**
None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Widowed |

6.(b) Name of husband or wife
Dec. 14, 1867

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Dec. 14, 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 72 | 9 | 10 | ..... hrs. ..... min. |

9. Birthplace Oldtown Md.
(Town, county, and state)

10. Usual occupation Blacksmith - Retired 12 yrs

11. Industry or business N. G. Taylor Tin Mill

FATHER
12. Name
13. Birthplace Unknown

MOTHER
14. Maiden name
15. Birthplace

16. Informant Mr. Walter Piper
Address Cumberland, Md.

17. burial Date thereof Sept. 27, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Fort Ashby Cemetery

Location Fort Ashby

18. Funeral director Louis Stein Inc.
Address Cumberland, Maryland

19. 9/26/ 1940 Joseph P. Franklin M.D. Registrar
(Date rec'd by registrar)

### MEDICAL CERTIFICATION

20. DATE OF DEATH 9/24/40 19..... at 7 p M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 9/12/40 19..... to 9/24/40 19.....
and that I last saw him alive on 9/23/40 19.....

Immediate cause of death — DURATION
Overwhelming Toxemia from Malignancy involving entire thorax

Due to Primary in bronchus. C.W.R.

Due to Also Chronic Myocarditis

Other conditions
Carcinoma was primary in bronchus. Duration: Unknown.
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Richard J. Milheim M.D.
M. D. or other

Address 3 + Va. Ave Date signed 9/25/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1940
BUREAU OF V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (53-a)

09261

## CERTIFICATE OF DEATH

Reg. Diat. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Country Home
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Mollie Pryor

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6. (a) ~~Single, married~~, widowed, or ~~divorced~~ |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband ~~or wife~~ Charles Pryor

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept 26, 1866

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 11 | 13 | hrs. min. |

9. Birthplace Sharpsburg, Md.
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name unknown

13. Birthplace " "

MOTHER 14. Maiden name unknown

15. Birthplace " "

16. Informant Wm. Clupston

Address 210 Milton St.

17. Burial Date thereof Sept. 11, 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Riverview Benfical Cem.

Location Cumberland, Md.

18. Funeral director Louis Stein & Son

Address Cumberland, Md.

19. Sept. 11, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 9-9-1940 at 2:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8-28-1940, to 9-9-1940, and that I last saw h ed alive on 9-9-1940

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Hemorrhage | 13 days |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings: None

Of operations

Of autopsy None

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. F. Williams M. D. ~~or other~~

Address Cumberland Date signed 9-10-40

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

WITHIN CORPORATE LIMITS

## CERTIFICATE OF DEATH

Dr. Latteys

09262 9

Reg. Dist. No.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Frostburg

(If outside city or town limits, write RURAL, NEAR and give town)

Street address, hospital, or institution: Miners Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Frostburg Md. Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No.

(If rural give LOCATION)

2(a) IF YETERAN, NAME WAR

**3. (a) FULL NAME** Baby Rank

**3. (b) Social Security Number** none

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

6.(b) Name of husband or wife

6.(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Sept. 22, 1940

8. AGE: Years | Months | Days | If less than one day: ____ hrs. ____ min.

Stillborn

9. Birthplace Frostburg Allegany Cty. Md. (Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Walter Rank

13. Birthplace Frostburg, Md.

MOTHER 14. Maiden name Mabel Powell

15. Birthplace Frostburg, Md.

16. Informant Walter Rank

Address Frostburg, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 21 1940 (month) (day) (year)

Cemetery or crematory Allegany Cemetery

Location Frostburg Md

18. Funeral director J. J. Hurst

Address Frostburg, Md.

19. Sept. 23 1940 (Date rec'd by registrar) M. A. R. Walker Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Sept 22 1940 at 8:15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__, and that I last saw h__ alive on ____ 19__.

| Immediate cause of death | DURATION |
|---|---|
| Stillborn | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. E. Latteys M.D. M. D. or other

Address Frostburg, Md. Date signed 9/23/40

RECEIVED
OCT 2 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

# CERTIFICATE OF DEATH

09263

Reg. Dist. No. 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland Md. (If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Charlestown

Stay in hospital or inst. (yrs., or mos., or days): —

Stay in this community (yrs., or mos., or days): 6 weeks

**2. USUAL RESIDENCE (HOME) OF DECEASED:** (For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Midland Md. Ward No. (If outside city or town limits, write RURAL NEAR and give town)

Street No.: — (If rural give LOCATION)

2(a) IF VETERAN, NAME WAR: —

**3. (a) FULL NAME:** Mary Jane Ravenscraft

**3. (b) Social Security Number:** —

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife: John Thomas Ravenscraft

6 (c) If alive, give age: — years

7. Birth date of deceased (mo., day, yr.): May 22, 1870

8. AGE: Years: 70 | Months: 3 | Days: 10 | If less than one day: — hrs. — min.

9. Birthplace: Farm Garrett Co., Md. (Town, county, and state)

10. Usual occupation: Housework

11. Industry or business: Home

FATHER — 12. Name: Isaac Swanger

FATHER — 13. Birthplace: Garrett Co. Md.

MOTHER — 14. Maiden name: — Layman

MOTHER — 15. Birthplace: Unknown

16. Informant: Mr. Ralph Ravenscraft

Address: Midland Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 4, 1940 (month) (day) (year)

Cemetery or crematory: Johnson

Location: Johnson Md.

18. Funeral director: Mr. Eichhorn

Address: Lonaconing, Md.

19. Sept 3 1940 (Date rec'd by registrar) E. Dorsey Taylor Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 2 1940, at 2A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 20 1940 to Sept 2 1940, and that I last saw h[illegible] alive on Sept 1st 1940.

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Hemorrhage | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations:

Of autopsy:

**PHYSICIAN** — Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury — Injured at work?

23. SIGNATURE: Henry D. Hodgson M.D. M. D. or other

Address: Lonaconing Md. Date signed: Sept 3 '40

RECEIVED
OCT 8 1940
BUREAU V. S.

arthur James

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (159)

## CERTIFICATE OF DEATH

09264

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 404 Furnace St.

(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Baby Boy Rice

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Male | white | Infant |

6 (b) Name of husband or wife

6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) SEPT. 20. 1940

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| Newborn | 0 | 0 | 4 hrs. min. |

9. Birthplace Cumberland

(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Harold Resley Rice

13. Birthplace Cumberland, Md.

MOTHER 14. Maiden name Mary Lee Baker

15. Birthplace Cumberland, Md. 404 Furnace St.,

16. Informant Mrs. Harold Rice

Address 404 Furnace St. City.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 20 1940 (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Cumberland, Md.

18. Funeral director J. C. Walford

Address Cumberland, Md.

19. 9/20/40 (Date rec'd by registrar) Joseph C. Franklin M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 20 1940, at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 20 1940, to Sept 20 1940, and that I last saw him alive on Sept. 20 1940.

| | DURATION |
|---|---|
| Immediate cause of death | |
| Prematurity (Two gestation) | |
| Due to | |
| Due to | |
| Other conditions | |
| (Include pregnancy within 3 months of death) | |
| Major findings: Of operations | |
| Of autopsy | |

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Arthur J. Jones M.D.

M. D. or other

Address 40 N. Liberty St. Date signed 9-20-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

Baltimore

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09265

Reg. Dist. No. 4

**1. PLACE OF DEATH:**
County ALLEGANY
City or town CUMBERLAND, MARYLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, Institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 471 BALTIMORE AVE.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME**
MRS. MARY AGNES RICE

**3.(b) Social Security Number**
None.

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| FEMALE | WHITE | WIDOWED |

6.(b) Name of husband or wife RICHARD C. RICE
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) MAY 17, 1867

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 73 | 3 | 19 | hrs. min. |

9. Birthplace MARYLAND (Town, county, and state)
10. Usual occupation HOUSE WORK
11. Industry or business
FATHER 12. Name GEORGE RICE
13. Birthplace PENNSYLVANIA
MOTHER 14. Maiden name SARAH DICKEN
15. Birthplace PENNSYLVANIA
16. Informant RUSSELL RICE
Address CUMBERLAND, MD,
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 7, 1940 (month) (day) (year)
Cemetery or crematory Hill Crest Cem.
Location Cumberland.
18. Funeral director J. C. Wolford
Address Cumberland, Md.
19. Sept. 6 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

DR. TREVASKIS

## MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 5, 1940 at 3:35 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1 1940 to Sept 5 1940 and that I last saw h alive on Sept 5 1940

| Immediate cause of death | DURATION |
|---|---|
| Cerebral hemorrhage | 5 days. |
| Due to | |
| Arterial hypertension | 2 yrs. |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE R. A. Trevaskis M. D. or other
Address Cumberland Md Date signed Sept 6-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-B)

09266

## CERTIFICATE OF DEATH

Reg. Dist. No. 8

**1. PLACE OF DEATH:**
County Allegany
City or town Lonaconing
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Douglas Avenue
Stay in hospital or inst. (yrs., or mos., or days) —
Stay in this community (yrs., or mos., or days) 76 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County
City or town Lonaconing Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Douglas Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR —

**3. (a) FULL NAME** Elizabeth Johnson Robertson

**3. (b) Social Security Number** —

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widow |

6 (b) Name of husband or wife David Robertson
6(c) If alive, give age — years

7. Birth date of deceased (mo., day, yr.) July 4, 1864

8. AGE: Years 76 | Months 1 | Days 28 | If less than one day — hrs. — min.

9. Birthplace Barton, Allegany, Md.
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER
12. Name Thomas Johnson
13. Birthplace Unknown

MOTHER
14. Maiden name Mary Ann Harvey
15. Birthplace England

16. Informant Mr. Harvey Robertson
Address Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 4 1940 (month) (day) (year)
Cemetery or crematory Oak Hill Cemetery
Location Lonaconing, Maryland

18. Funeral director Mr. Eichhorn
Address Lonaconing, Md.

19. Sept. 3 19 40 (Date rec'd by registrar) E. Don Taylor Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2nd 1940, at 5:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 1939, to Sept 2 1940, and that I last saw h-- alive on Aug 25th 1940.

| | DURATION |
|---|---|
| Immediate cause of death Carcinoma of Stomach | About 1 year |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide — Date of —
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) —
Means of injury — Injured at work?

23. SIGNATURE Henry W. Hodgson M.D.
M. D. or other
Address Lonaconing, Md. Date signed Sept 3 1940

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

ECEIVED
OCT 8 1940
REAU V. S.

WITHIN CORPORATE LIMITS.

09267

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (33-B)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland.
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Memorial Hospital

Stay in hospital or inst. (yrs., or mos., or days) 5 days.

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. 322 Bond St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Mrs Ethel C. Robertson

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Married |

6 (b) Name of husband ~~or wife~~ John Guy Robertson

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) May 10, 1899

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 41 | 4 | 15 | ____ hrs. ____ min. |

9. Birthplace Pennsylvania.
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

FATHER
12. Name Luther Howser
13. Birthplace Pa.

MOTHER
14. Maiden name Mary Ruby
15. Birthplace Pa.

16. Informant Husband.

Address 322 Bond St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 28, 1940 (month) (day) (year)

Cemetery or crematory Zion Memorial Cemetary

Location Bedford Rd. Cumbd.

18. Funeral director V. L. Lemperleur

Address 302 Green St. Cumberland.

19. Sept. 27 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 9-25-1940, at 11:15 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-20-1940 to 9-25-1940 and that I last saw her alive on 9-25-1940.

Immediate cause of death: Postinfluenzal Encephalitis

DURATION of whs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings:
Of operations None.

Of autopsy None.

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Cate of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE J. F. Williams M. D. or other

Address Cumberland Date signed 9/26/40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (61)

## CERTIFICATE OF DEATH

09268

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: 18 Elder street
Stay in hospital or inst. (yrs., or mos., or days):
Stay in this community (yrs., or mos., or days):

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.: 18 Elder Street
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** Matilda Agnes Robertson

**3. (b) Social Security Number:** None

4. Sex: F
5. Color or race: W
6. (a) Single, married, widowed, or divorced: Widow
6 (b) Name of husband ~~or wife~~: Luke Robertson
6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): April 4, 1860

8. AGE: Years: 80 Months: 5 Days: 6 If less than one day: hrs. min.

9. Birthplace: Green Ridge Allegany Co Md
(Town, county, and state)

10. Usual occupation: House duty

11. Industry or business: Own House

FATHER
12. Name: Wm B middleton
13. Birthplace: Gilpintown Md

MOTHER
14. Maiden name: Nancy Whore
15. Birthplace: Dont Know

16. Informant: Carl Robertson
Address: 812 Calvin St Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 16/40 (month) (day) (year)
Cemetery or crematory: Greenmount
Location: Cumberland Md

18. Funeral director: William F. Kight
Address: Cumberland Md

19. Sept. 16 1940 (Date rec'd by registrar) J. O. Franklin Registrar M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 14 1940 at 1.30 A M

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Oct. 1938 to Sept 10 1940
and that I last saw h~~e~~ alive on Sept 10 1940

Immediate cause of death: Diabetes Mellitus — DURATION: ?
Due to: Arteriosclerosis
Due to:
Other conditions:
(Include pregnancy within 3 months of death)

Major findings:
Of operation: Both legs amputated two years ago.
Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: W Royce Hodges, M.D.
Address: Cumberland, Md M. D. or other: Date signed: 9/14/40

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (14)

09269

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County ALLEGANY

City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL

How long in hospital or institution? 13 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State MARYLAND County ALLEGANY

City or town OLDTOWN
(If outside city or town limits, write RURAL and give nearest town)

Street No.
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** RALPH SCHAIDT

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | SINGLE |

6.(b) Name of husband or wife ——

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) JUNE 2, 1928

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 12 | 3 | 22 | ..... hrs. ..... min. |

9. Birthplace MARYLAND
(Town, county, and state)

10. Usual occupation STUDENT

11. Industry or business

FATHER
12. Name CARL SCHAIDT (DECEASED)
13. Birthplace Md.

MOTHER
14. Maiden name SYLVIA ROBERTSON (CRABTREE)
15. Birthplace MARYLAND (/remarried)

16. Informant Mrs Frank L. Crabtree
Address Oldtown Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 25 40 (month) (day) (year)

Cemetery or crematory Oldtown Cem.

Location Oldtown Md.

18. Funeral director Louis Stein Inc.
Address Cumberland Md.

19. 9/26/ 1940 (Date rec'd by registrar) Joseph P. Franklin M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH SEPTEMBER 24, 1940, at 5:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-11-40 19..., to 9-24-40 19...
and that I last saw h. in alive on 9-24-40 19...

| | DURATION |
|---|---|
| Immediate cause of death: meningitis - Probably Tuberculous. However, Tuberculous bacillus was not isolated. | 17 days |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Alfred Van Ormer M. D. or other

Address Cumberland, Md. Date signed 9-25-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

I

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09270

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital, Cumberland, Md.

Stay in hospital or inst. (yrs., or mos., or days): 1 Day

Stay in this community (yrs., or mos., or days): All but life

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants, give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No.: 725 Greene St
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR:

**3. (a) FULL NAME:** James M. Shields

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Single |

8 (b) Name of husband or wife:

6(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): Apr. 4 - 1876

**8. AGE:**

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 64 | 5 | 26 | hrs. min. |

9. Birthplace: Berkeley Shaft, Md.
(Town, county, and state)

10. Usual occupation: Trading Salesman

11. Industry or business:

FATHER
12. Name: James Shields
13. Birthplace: Ireland

MOTHER
14. Maiden name: Margaret Barr
15. Birthplace: Ireland

16. Informant: Mrs Thos. Arnold
Address: Mt. Savage, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Oct. 2. 1940 (month) (day) (year)

Cemetery or crematory: St. Michaels

Location: Frostburg, Md.

18. Funeral director: Jacob Kaufer

Address: Frostburg, Md.

19. Oct. 1 1940 (Date rec'd by registrar) J. L. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 30, 1940, at 12:55 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 30, 1940 to Sept. 30, 1940, and that I last saw him alive on September 30, 1940.

| | DURATION |
|---|---|
| Immediate cause of death: Coronary occlusion | 12 hrs. |
| Due to: Chronic myocarditis | Unknown |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations:

Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?):

Means of injury: Injured at work?

23. SIGNATURE: W. M. Shields, M. D. or other

Address: Cumberland, Md. Date signed: 10-1-40

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

09271

## CERTIFICATE OF DEATH

Reg. Diat. No. 4

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 5 hours
Hospital, institution, or street address where death occurred: Allegany Hospital
How long in hospital or institution? 5 hours

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants, give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.: [illegible]
(If rural, give LOCATION)
2.(a) If veteran, name war: -

**3. (a) FULL NAME:** John Joseph Shockey

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Child |

6.(b) Name of husband or wife: -
6.(c) If alive, give age: - years

7. Birth date of deceased (mo., day, yr.): June 23, 1940

8. AGE: Years: | Months: 2 | Days: 22 | If less than one day: hrs. min.

9. Birthplace: Lonaconing, Allegany Co., Maryland (Town, county, and state)

10. Usual occupation: None

11. Industry or business:

FATHER
12. Name: Edgar Lee Shockey
13. Birthplace: Lonaconing, Md.

MOTHER
14. Maiden name: Mary Wicker
15. Birthplace: Lonaconing, Md.

16. Informant: Charles Shockey
Address: Lonaconing, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 17 1940 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing, Md.

18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.

19. 9/17/40 (Date rec'd by registrar) Joseph R. Franklin M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Sept. 15 1940, at 7 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 14 1940, to - 19..
and that I last saw him alive on Sept 15 1940.

| Immediate cause of death | DURATION |
|---|---|
| Bronchio-Pneumonia | 3 days |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: -
Date of op.: -
Autopsy results: -
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: - Date of: -
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?): -
Means of injury: - Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D. M. D. or other
Address: Lonaconing, Md. Date signed Sept. 16 1940

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (446)

## CERTIFICATE OF DEATH

09272

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

**1. PLACE OF DEATH:**
County ALLEGANY
City or town CUMBERLAND, MD.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State MARYLAND County ALLEGANY
City or town CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
Street No. 37 N. MECHANIC ST.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3. (a) FULL NAME** MR. HUGO SILVESTRI.

219-03-8571

**3. (b) Social Security Number** 217-10-6871

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | MARRIED |

6.(b) Name of husband or wife CONDA BIAGI
6.(c) If alive, give age 49 years
7. Birth date of deceased (mo., day, yr.) AUGUST 18, 1888.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 52 | — | 17. | ..... hrs. ..... min. |

9. Birthplace ITALY
(Town, county, and state)
10. Usual occupation UNABLE TO WORK
11. Industry or business Fruit Merchant
FATHER 12. Name BASILIO SILVESTRI
13. Birthplace ITALY
MOTHER 14. Maiden name Unknown
15. Birthplace ITALY
16. Informant GANDA SILVESTRI
Address 37 N. MECHANIC ST. CUMBERLAND, MD.
17. Burial Date thereof Sept. 7. '40
(Burial, cremation, or removal. Which?) (Month) (day) (year)
Cemetery or crematory St. Peter & Paul
Location Cumberland, Md.
16. Funeral director Louis Stein Inc.
Address Cumberland, Md.
19 Sept. 6, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

DR. ZIMMERMAN

## MEDICAL CERTIFICATION

20. DATE OF DEATH SEPT. 4, 1940 11:45 P.M. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Nov. 1, 1939 to Sept. 4 1940
and that I last saw h[illegible] alive on Sept. 4, 1940

| Immediate cause of death | DURATION |
|---|---|
| Hodgkins Disease | Nov. 1, 1939 |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations ..... Date of op. .....
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. C. Zimmerman M.D.
M. D. or other
Address ..... Date signed 9-5-40

RECEIVED
SEP 11 1940
BUREAU V. S.

CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 170-C

09273

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Allegany Hospital

Stay in hospital or inst. (yrs., or mos., or days) dead on arrival

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Md County Allegany

City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)

Street No. Braddock Road
(If rural give LOCATION)

2(a) IF VETERAN, NAME WAR No

**3. (a) FULL NAME** George Addison Smith

**3. (b) Social Security Number** 219-03-9664

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced Single

6 (b) Name of husband or wife Single

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) December 21, 1922

**8. AGE:** Years 17 Months 8 Days 23 If less than one day ____ hrs. ____ min.

9. Birthplace Kitzmiller Md
(Town, county, and state)

10. Usual occupation Student previously Laborer

11. Industry or business Ice Cream factory

FATHER
12. Name Chas. Wm Smith
13. Birthplace Winchester Va

MOTHER
14. Maiden name Myrtle Stewart
15. Birthplace Kitzmiller, Md.

16. Informant Joseph Smith
Address Cumberland Md

17. Burial (Burial, cremation, or removal Which?) Date thereof Sept 17 1940 (month) (day) (year)

Cemetery or crematory Porter Cem.

Location Echart, Md.

18. Funeral director Jacob Hafer
Address Cumberland

19. 9/17/ 1940 (Date rec'd by registrar) J. A. Franklin, M.D. Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 14, 1940, at 11:30 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from none 19__, to none 19__, and that I last saw h none 19__.

Immediate cause of death Crushed Chest — DURATION sudden

Due to Accident

Due to Dead when I saw at Allegany Hospital

Other conditions
(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

PHYSICIAN
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 9-15-40

Where did injury occur? Near Romney, W. Va.
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Public

Means of injury Automobile Injured at work? No

23. SIGNATURE C. C. Zimmerman M. D. or other

Address Cumberland Md Date signed 9-15-40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

Dr. Zim

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (83-a)

## CERTIFICATE OF DEATH

09274

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland (If outside city or town limits, write RURAL NEAR and give town) Md.
Street address, hospital, or institution: 317 Magruder Sts
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants, give residence of mother)
State Md. County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 317 Magruder St. (If rural, give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Mrs Kezia Whalley Smith.

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Widowed |

6 (b) Name of husband or wife Henry C Smith.
(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) Unknown 1858

8. AGE: Years 82 | Months ? | Days ? | If less than one day ____ hrs. ____ min.

9. Birthplace Staffordshire, England. (Town, county, and state)

10. Usual occupation Home

11. Industry or business

FATHER 12. Name John C Whalley
13. Birthplace England

MOTHER 14. Maiden name Sarah Butler
15. Birthplace England

16. Informant Mr Edward Grass
Address Cumberland Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 4 40 (month) (day) (year)
Cemetery or crematory Rose Hill Cemetery
Location Cumberland, Md.

18. Funeral director Lewis Stein Bros
Address Cumberland, Md.

19. Sept 4 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 2nd 1940, at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 20 1940 to Sept 2nd 1940, and that I last saw h e alive on Sept 2nd 1940

| Immediate cause of death | DURATION |
|---|---|
| Cerebral Hemorrhage | 13 days |
| Due to | |
| Due to | |
| Other conditions General Paralysis Left Arm & Leg | 2 yrs |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE C. L. Owens M D M. D. or other
Address Cumberland Md Date signed Sept 3 1940

RECEIVED
OCT 7 1940
U. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-6)

## CERTIFICATE OF DEATH

Mc Lane
09275 9
Reg. Dist. No.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

**1. PLACE OF DEATH:**
County Allegany
City or town Frostburg Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Miners Hospital
Stay in hospital or insl. (yrs., or mos., or days) 3 days
Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Maryland County Allegany
City or town Bihlman Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** Emma Stevens

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6. (a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6 (b) Name of husband or wife
6(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) Sept. 12, 1881

8. AGE: Years 59 Days 4 If less than one day hrs. min.

9. Birthplace Bihlman Allegany Cty. Md.
(Town, county, and state)

10. Usual occupation housekeeper

11. Industry or business at home

FATHER
12. Name Theopilus Stevens
13. Birthplace Maryland

MOTHER
14. Maiden name Amanda Middleton
15. Birthplace Maryland

16. Informant Roy Stevens
Address Bihlman Md.

17. Burial
(Burial, cremation, or removal. Which?) Date thereof Sept 19-1940
(month) (day) (year)
Cemetery or crematory Jersey Cemetery
Location Frostburg Md.

18. Funeral director J. J. Durst
Address Frostburg Md.

19. Sept. 18 1940 Mrs. A. R. Walker
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Sept 16 1940 at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 4 1940 to Sept 16 1940; and that I last saw her alive on Sept 16 1940.

| | DURATION |
|---|---|
| Immediate cause of death Carcinoma of Stomach | 3 |
| Due to | 1 |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations —
Of autopsy —

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE W. McLane Jr MD
M. D. or other
Address Frostburg Md Date signed 9-17-40

RECEIVED
OCT 2 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09276

(131-B)

## CERTIFICATE OF DEATH

Reg. Dist. No. 2

**1. PLACE OF DEATH:**

County: Allegany

City or town: Flintstone Route # 2

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: Flintstone

(If outside city or town limits, write RURAL and give nearest town)

Street No.: Route # 2

(If rural, give LOCATION)

2.(a) If veteran, name war: No

**3.(a) FULL NAME:** Wilmer Scott Stonestreet

**3.(b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| M | W | Married |

6.(b) Name of husband or wife: Almeda Weimer Stonestreet

6.(c) If alive, give age: 63 years

7. Birth date of deceased (mo., day, yr.): Nov 28 1879

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 60 | 9 | 9 | ... hrs. ... min. |

9. Birthplace: Jordans Run W Va (Town, county, and state)

10. Usual occupation: Farmer

11. Industry or business: Own Farm

FATHER — 12. Name: Jason Stonestreet

FATHER — 13. Birthplace: Jordans Run W Va.

MOTHER — 14. Maiden name: Rubama Seavers

MOTHER — 15. Birthplace: Pendleton Co. W Va

16. Informant: Earl Stonestreet

Address: Flintstone Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 9 1940 (month) (day) (year)

Cemetery or crematory: Green Meadow

Location: Mulley Branch Flintstone

18. Funeral director: Scott Bates

Address: Cumberland

19. Sept 9 1940 (Date rec'd by registrar) D. Bennett Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Sept 7 1940 at 4:00 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1 1940 to Sept 7 1940

and that I last saw h... alive on Sept 7 1940

| Immediate cause of death | DURATION |
|---|---|
| Cardiac Hypertrophy | 2 |
| Due to: Pulmonary Edema | 3 days |
| Due to: Chronic Nephritis | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ... Date of op. ...

Autopsy results: ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ... Date of ...

Where did injury occur? ... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ...

Means of injury ... Injured at work?

23. SIGNATURE: W Boyce Hodges M. D. M. D. or other

Address: Cumberland Md Date signed 9/9/40

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

Dr Hodges

RECEIVED
OCT 3 1940
U. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (117-a)

## CERTIFICATE OF DEATH

09277

Reg. Dist. No. 6

**1. PLACE OF DEATH:**
County Allegany
City or town Westernport, Md
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Spruce St.
Stay in hospital or inst. (yrs., or mos., or days)
Stay in this community (yrs., or mos., or days) 62 years

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State Md. County Allegany
City or town Westernport Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. Spruce St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR

**3. (a) FULL NAME** James Patrick Sullivan

**3. (b) Social Security Number** 212-03-4767

4. Sex: Male
5. Color or race: White
6. (a) Single, married, widowed, or divorced: Widowed
6 (b) Name of husband or wife: Elizabeth Gay Sullivan
6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.): August 8, 1878

8. AGE: Years 62 | Months 0 | Days 24 | If less than one day: ____ hrs. ____ min.

9. Birthplace: Westernport, Alleg. Md.
(Town, county, and state)

10. Usual occupation: Miner

11. Industry or business: Coal Mine

FATHER
12. Name: Michael J. Sullivan
13. Birthplace: Ireland

MOTHER
14. Maiden name: Unknown
15. Birthplace: "

16. Informant: Mrs. Hilda Sullivan
Address: Spruce St. Westernport

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept. 6 1940 (month) (day) (year)
Cemetery or crematory: Serenity Point Cem.
Location: Keyser, W. Va.

18. Funeral director: E. Haworth S. Boal
Address: Westernport, Md

19. Sept. 5 1940 (Date rec'd by registrar) G. Baginbaker M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Sept. 3, 1940, at 7:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 3 1940, to Sept 3 1940, and that I last saw h alive on Dead when seen 19

| | DURATION |
|---|---|
| Immediate cause of death: Hemorrhage | |
| Due to: Peptic ulcer | 10 yrs |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations:
Of autopsy:

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, Industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE James H. Wolverton, Jr. MD M. D. or other
Address Piedmont W. Va Date signed 9/5/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 5 1940
BUREAU V. S.

Outside of City Limits

09278

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

95-C

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland La Vale
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, institution, or street address where death occurred: National Highway La Vale

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Md. County: Allegany

City or town: La Vale
(If outside city or town limits, write RURAL and give nearest town)

Street No.: National Highway
(If rural, give LOCATION)

2.(a) If veteran, name war: World War I

**3.(a) FULL NAME:** Raymond Robert Tiley

**3.(b) Social Security Number:** 712-14-1601

4. Sex: M

5. Color or race: W

6.(a) Single, married, widowed, or divorced: married

6.(b) Name of husband or wife: Nannie Lylia Tiley

6.(c) If alive, give age: 44 years

7. Birth date of deceased (mo., day, yr.): Apr. 19, 1893

**8. AGE:** Years 47 | Months 4 | Days 21 | If less than one day ..... hrs. ..... min.

9. Birthplace: Saint Clair, Pa
(Town, county, and state)

10. Usual occupation: Civil Engineer

11. Industry or business: Rail Road

FATHER
12. Name: John Wm. Tiley
13. Birthplace: Germany

MOTHER
14. Maiden name: Anna Umlauf
15. Birthplace: Germany

16. Informant: Mrs. Nannie Tiley
Address: La Vale Md

17. Burial
(Burial, cremation, or removal. Which?)
Date thereof: Sept 12, 1940
(month) (day) (year)

Cemetery or crematory: Hill Crest

Location: Cumberland

18. Funeral director: Jacob Hofer

Address: Cumberland, Md

19. Sept. 11, 1940 J. P. Franklin, M.D.
(Date rec'd by registrar) Registrar

H. V. Deming

### MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 10 1940, at 3:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 10 1940, to Sept 10 1940 and that I last saw him alive on Sept. 10 1940

| Immediate cause of death | DURATION |
|---|---|
| Acute dilatation of the heart | at once |
| Due to: acute indigestion | 2 hrs |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op.

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: ..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: H. V. Deming M.D.
M. D. or other

Address: 67 N. Center St. Date signed: 9-11-40

VS A15

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 23 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

09279

Reg. Dist. No. 4

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:
39 Mary St

How long in hospital or Institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State: Maryland County: Allegany

City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 39 Mary St
(If rural give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME:** Rachael Virginia Zucker

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Widowed |

6.(b) Name of husband ~~or wife~~: Mason Zucker

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.): August 25, 1857

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 86 | 0 | 13 | ..... hrs. ..... min. |

9. Birthplace: West Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business

FATHER
12. Name: Joe McNemar
13. Birthplace: West Va.

MOTHER
14. Maiden name: Rachel Bradford
15. Birthplace: West Va.

16. Informant: Mrs Mary Hallerman

Address: 39 Mary St.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 10 1940 (month) (day) (year)

Cemetery or crematory: Rose Hill Cemetery

Location: Cumberland Md

18. Funeral director: Louis Stein Inc.

Address: Cumberland Md.

19. Sept. 9 1940 (Date rec'd by registrar) J. P. Franklin, M.D. Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: September 8 1940, at 10 P. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from September 4 1940 to Sept. 8 1940 and that I last saw her alive on September 8 1940

Immediate cause of death: Influenza — DURATION: 4 days.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operations:

Date of op.:

Autopsy results:

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide: Date of:

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: J. P. McCarty M.D.
M. D. or other

Address: Cumberland Md Date signed: 9/9/40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

09280

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (112)

## CERTIFICATE OF DEATH

Reg. Dist. No. 8

**1. PLACE OF DEATH:**
County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 66 yrs
Hospital, Institution, or street address where death occurred: West Main Street
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.: West Main Street
(If rural, give LOCATION)
2.(a) If veteran, name war:

**3.(a) FULL NAME:** David Dobson Turnbull

**3.(b) Social Security Number:** 212-12-8465

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Male | White | Married |

6.(b) Name of husband or wife: Elizabeth M. J. D. Turnbull
6.(c) If alive, give age: 66 years

7. Birth date of deceased (mo., day, yr.): Sept 27, 1869

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 11 | 19 | ...hrs. ...min. |

9. Birthplace: Scotland (Town, county, and state)
10. Usual occupation: Miner
11. Industry or business: Coal Mine
12. FATHER — Name: Robert P. Turnbull
13. FATHER — Birthplace: Scotland
14. MOTHER — Maiden name: Christina Dobson
15. MOTHER — Birthplace: Scotland
16. Informant: Mrs. Wm. L. Turnbull
Address: Lonaconing, Md.
17. Burial (Burial, cremation, or removal? Which?) Date thereof: Sept 19 1940 (month) (day) (year)
Cemetery or crematory: Laurel Hill Cemetery
Location: Lonaconing, Md.
18. Funeral director: M. Eichhorn
Address: Lonaconing Md
18. Sept. 14 1940 (Date rec'd by registrar) E. Dan Hyla Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept 16 1940, at 9:30 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 1st 19... to Sept 16 1940
and that I last saw h... alive on Sept 16 1940
Immediate cause of death: Chronic Bronchitis Asthma with Dilatation of Heart

| DURATION |
|---|
| |
| |
| |
| |
| |
| |
| |

Due to:
Due to:
Other conditions:
(Include pregnancy within 3 months of death)
Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D.
M. D. or other
Address: Lonaconing Md Date signed: Sept. 19 '40

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-d)

## CERTIFICATE OF DEATH

09281

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:
1115 Bedford St.

How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)

State Maryland County Allegany

City or town Cumberland
(If outside city or town limits, write RURAL and give nearest town)

Street No. 1115 Bedford St
(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Mrs. Agnes Nettie Valentine

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Feminine | White | Married |

6.(b) Name of husband or wife William T. Valentine

6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept. 1, 1878

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 62 | No | 12 | ..... hrs. ..... min. |

9. Birthplace Cumberland Md
(Town, county, and state)

10. Usual occupation Housework

11. Industry or business Home

FATHER
12. Name Benjamin Brant
13. Birthplace Md

MOTHER
14. Maiden name Jane Hall
15. Birthplace Md

16. Informant Wm. T. Valentine
Address Cumberland Md

17. Burial Date thereof Sept 15 1940
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Hillcrest Bur. Park

Location Cumberland Md

18. Funeral director Louis Steitz Inc

Address Cumberland Md

19. Sept 14 1940 Joseph P. Franklin RS
(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH Sept. 13 1940, at 5 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 3-23- 1936, to 9-13- 1940

and that I last saw her alive on 9-12-40 19....

| Immediate cause of death | DURATION |
|---|---|
| Auricula-Ventricular Block. Myocarditis Chronic | 10-12 yrs |
| Due to Chronic Allergic Asthma | 15 yrs |
| Due to Ch. Nasal accessory sinusitis. | 15 yrs. |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Leslee E. Daugherty
M. D. or other

Address 7 Washington St Date signed 9-13-40

RECEIVED
OCT 7 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1248)

## CERTIFICATE OF DEATH

09282

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County Allegany
City or town Cumberland
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution: Allegany Hospital
Stay in hospital or inst. (yrs., or mos., or days) 6 days
Stay in this community (yrs., or mos., or days) 10 years

**2. USUAL RESIDENCE (HOME) OF DECEASED**
(If newborn infants give residence of mother)
State Md. County Allegany
City or town Cumberland Ward No.
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 125 Bedford St.
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR No

**3. (a) FULL NAME** Helen Louise Walbert

**3. (b) Social Security Number** 214-05-8015

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| F | W | Separated |

6 (b) Name of husband or wife Thomas S. Walbert
6(c) If alive, give age 43 years

7. Birth date of deceased (mo., day, yr.) Jan 27, 1897

8. AGE:

| Years | Months | Days | If less than one day |
|---|---|---|---|
| 43 | 7 | 25 | hrs. min. |

9. Birthplace Mt. Savage Md.
(Town, county, and state)
10. Usual occupation Maid
11. Industry or business Windsor Hotel

FATHER
12. Name
13. Birthplace

MOTHER
14. Maiden name Harriet Elizabeth Holtzman
15. Birthplace Mt. Savage Md

16. Informant Thomas Walbert
Address 125 Bedford St. Cumberland

17. Burial (Burial, cremation, or removal? Which?) Date thereof Sept 22, 1940 (month) (day) (year)
Cemetery or crematory Rose Hill
Location Cumberland, Md
18. Funeral director Jacob Lopez
Address Cumberland, Md.

19. Sept 25 1940 (Date rec'd by registrar) Joseph C. Franklin M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 22 1940, at 12:20 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/15/40 19 to 9/22/40 19, and that I last saw h alive on 9/22/40 19

| Immediate cause of death | DURATION |
|---|---|
| cerebral hemorrhage | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:
Of operations
Of autopsy

**PHYSICIAN**
Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John K Rozzell M.D.
M. D. or other
Address Cumberland Md Date signed 9/25/40

Dr Rozzell

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 55-P

09283

## CERTIFICATE OF DEATH

Reg. Dist. No. 8

**1. PLACE OF DEATH:**
County: Allegany.
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 45 yrs 4 mos
Hospital, institution, or street address where death occurred:
Waterscliffe
How long in hospital or institution? —

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Lonaconing
(If outside city or town limits, write RURAL and give nearest town)
Street No.: Waterscliffe
(If rural, give LOCATION)
2.(a) If veteran, name war: —

**3.(a) FULL NAME:** Jennie Anderson Walters

**3.(b) Social Security Number:** —

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | married |

6.(b) Name of husband or wife: Charles J. Walters
6.(c) If alive, give age: 49 years

7. Birth date of deceased (mo., day, yr.): May 16, 1895

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 45 | 4 | 8 | ..... hrs. ..... min. |

9. Birthplace: Lonaconing, Allegany Co., Md.
(Town, county, and state)
10. Usual occupation: Housework
11. Industry or business: Home
FATHER 12. Name: Lohas Anderson
FATHER 13. Birthplace: Scotland
MOTHER 14. Maiden name: Isabel Miller
MOTHER 15. Birthplace: Davis Mountain Near Lonaconing
18. Informant: Mrs. Lohas A. Walters
Address: Lonaconing Md.
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept. 18, 1940 (month) (day) (year)
Cemetery or crematory: Oak Hill Cemetery
Location: Lonaconing Md.
18. Funeral director: M. Eichhorn
Address: Lonaconing, Md.
19. Sept. 17 1940 (Date rec'd by registrar) E. Dow Taylor Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 16th 1940, at 9:30 A. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 14 1940 to Sept 16 1940
and that I last saw h... alive on Sept 15 1940

| Immediate cause of death | DURATION |
|---|---|
| Carcinoma of left breast | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations: ..... Date of op. .....
Autopsy results: .....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury ..... Injured at work?

23. SIGNATURE: Henry M. Hodgson M.D.
M. D. or other
Address: Lonaconing, Md. Date signed: Sept. 16, 40.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

RECEIVED
OCT 8 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (940)

## CERTIFICATE OF DEATH

09284

Reg. Diat. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred: 111 South Lee St
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Md County: Allegany
City or town: Cumberland (If outside city or town limits, write RURAL and give nearest town) Md.
Street No.: 111 South Lee St (If rural, give LOCATION)
2.(a) If veteran, name war:

**3. (a) FULL NAME:** Alberta G Washington

**3. (b) Social Security Number:** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | Colored | married |

6.(b) Name of husband or wife: Nannie C Turner
6.(c) If alive, give age: years
7. Birth date of deceased (mo., day, yr.): Feb 7. 1869.

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 71 | 7 | 2 | hrs. min. |

9. Birthplace: Cumberland Md. (Town, county, and state)
10. Usual occupation: Barber.
11. Industry or business: Own Business
FATHER 12. Name: Thomas G Washington
13. Birthplace: Md.
MOTHER 14. Maiden name: Not Known.
15. Birthplace
16. Informant: Mrs G W Robinson
Address: Cumb. Md
17. Buried (Burial, cremation, or removal. Which?) Date thereof: Sept 11 40 (month) (day) (year)
Cemetery or crematory: Summerhill Cemetery
Location: Cumberland Md
18. Funeral director: Louis Steinbrenner
Address: Cumberland Md
19. Sept 9 1940 (Date rec'd by registrar) J. Franklin, M.D. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: Sept. 9, 1940, at 12:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 8 1940, to Sept 9 1940
and that I last saw him alive on Sept 7 1940

| Immediate cause of death | DURATION |
|---|---|
| (Myocarditis) | 1 mo |
| Coronary occlusion | 1 Dec. |
| Due to: myocarditis | 1 mo. |
| Due to: | |
| Due to: | |
| Other conditions: | |

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: George C. Holloman M.D. M. D. or other
Address: 145 Hanover St Date signed: Sept 9 40

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (94a)

## CERTIFICATE OF DEATH

09285

Reg. Dist. No. 4

WITHIN CORPORATE LIMITS

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

**1. PLACE OF DEATH:**

County Allegany

City or town Cumberland, md

(If outside city or town limits, write RURAL NEAR and give town)

Street address, hospital, or institution: Cumberland, Md. - B & O R R Palmer

Stay in hospital or inst. (yrs., or mos., or days)

Stay in this community (yrs., or mos., or days)

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State Virginia County

City or town Roanoke Ward No.

(If outside city or town limits, write RURAL NEAR and give town)

Street No. 1139 Commerce St.

(If rural, give LOCATION)

2(a) IF VETERAN, NAME WAR - Civil War

**3. (a) FULL NAME** John E. Whitehouse

**3. (b) Social Security Number** 237-10-1140

| 4. Sex | 5. Color or race | 6. (a) ~~single~~, married, widowed, or divorced |
|---|---|---|
| male | White | married |

6 (b) Name of ~~husband~~ or wife Verna M. Whitehouse

6(c) If alive, give age ____ years

7. Birth date of deceased (mo., day, yr.) July 8, 1900

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 40 | 3 | 18 | ____ hrs. ____ min. |

9. Birthplace Pittsburg, Pa.

(Town, county, and state)

10. Usual occupation Salesman

11. Industry or business Pittsburgh Steel Co.

FATHER 12. Name Thomas E Whitehouse

13. Birthplace U.S.A.

MOTHER 14. Maiden name Eva Johnson

15. Birthplace U.S.A.

16. Informant Verna Whitehouse

Address 1139 Commerce St, Roanoke, Va.

17. Burial Rainbal Date thereof Sept 26 1940

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Columbia Chapel

Location Columbia Chapel

18. Funeral director Louis Stein Inc.

Address Cumberland, md

19. 9/26/ 1940 Joseph B Frankler

(Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH September 26 1940, at about 1.30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from ____ 19__, to ____ 19__; and that I last saw h__ alive on ____ 19__

| Immediate cause of death | DURATION |
|---|---|
| Coronary occlusion | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings:

Of operations

Of autopsy None

**PHYSICIAN**

Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ____ Date of ____

Where did injury occur? ____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ____

Means of injury ____ Injured at work?

23. SIGNATURE Prince H. Brown, M.D. M. D. or other

Address Cumberland, Md. Date signed 9/26/40

Deputy Medical Examiner - Allegany Co.

VS A15

RECEIVED
OCT 7 1940
BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH
2411 N. Charles St., Baltimore (74a)

# CERTIFICATE OF DEATH

09286

Reg. Dist. No. 9

**1. PLACE OF DEATH:**
County: Allegany
City or town: Zihlman Md
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? All her life
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Zihlman
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3. (a) FULL NAME:** Margaret Williams

**3. (b) Social Security Number:** none

4. Sex: Female
5. Color or race: White
6.(a) Single, married, widowed, or divorced: Married
6.(b) Name of husband or wife: Elias Williams
6.(c) If alive, give age: 59 years
7. Birth date of deceased (mo., day, yr.): Aug. 6 - 1885

**8. AGE:** Years 55 | Months 0 | Days 29 | If less than one day ... hrs. ... min.

9. Birthplace: Zihlman Md
(Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business
FATHER
12. Name: John Koontz
13. Birthplace: Zihlman, Md
MOTHER
14. Maiden name: Laura Stevens
15. Birthplace: Md
16. Informant: Elias Williams
Address: Zihlman, Md
17. Burial (Burial, cremation, or removal. Which?) Date thereof: Sept 7 - 1940 (month) (day) (year)
Cemetery or crematory: Allegany Cemetery
Location: Frostburg, Md
18. Funeral director: Jacob Vader
Address: Frostburg, Md
19. Sept. 7th 1940 (Date rec'd by registrar) Mrs. A. R. Walker Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH: September 5 1940, at 12:15 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 22 1940, to Sept. 5 1940
and that I last saw her alive on Sept. 3 1940
Immediate cause of death: Cardiac failure
Due to: Acute Lymphatic Leukemia — DURATION: 3 weeks +
Due to:
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: William C. Harrison M.D. M. D. or other
Address: Mount Savage, Md Date signed: 9/6/40

VS A15 MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
OCT 2 1940
BUREAU V. S.

WITHIN CORPORATE LIMITS.

09287

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (96)

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: ALLEGANY
City or town: CUMBERLAND
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
MEMORIAL HOSPITAL
How long in hospital or institution? 9 DAYS

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: MARYLAND County: GARRETT
City or town: CRELLIN
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3.(a) FULL NAME:** ARTHUR WILT

**3.(b) Social Security Number:** 213-10-3705

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| MALE | WHITE | MARRIED |

6.(b) Name of husband or wife: RUTH JAMISON WILT
6.(c) If alive, give age: 28 years

7. Birth date of deceased (mo., day, yr.): AUGUST 18, 1906

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 34 | 1 | 3 | ...hrs. ...min. |

9. Birthplace: MARYLAND (Town, county, and state)
10. Usual occupation: COAL MINER
11. Industry or business

FATHER
12. Name: EDWARD WILT
13. Birthplace: CRELLIN, MD.

MOTHER
14. Maiden name: ARLETTA FITZWATER
15. Birthplace: SWANTON, MD.

16. Informant: RUTH JAMISON WILT
Address: CRELLIN, MARYLAND

17. Burial (Burial, cremation, or removal. Which?) Date thereof: sept 23 1940 (month) (day) (year)
Cemetery or crematory: ASHBY CEMETERY
Location: CRELLIN, MD.
18. Funeral director: Emroy Baldem
Address: Oakland Md

19. 9/23/ 19 40 (Date rec'd by registrar) Joseph R. Franklin M.D. Registrar

Dec Brodrick-Lemke

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: SEPTEMBER 21, 1940, at 7:35 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 12 1940 to Sept. 21 1940 and that I last saw her alive on Sept 21 1940

| Immediate cause of death | DURATION |
|---|---|
| Heart Embolism | |
| Due to: Poliomyelitis | 9 days |
| Due to: A ruptured aneurysm in the circle of Willis. cured 1-16-1941 | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results: Autopsy No evidence of poliomyelitis
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: I.T. Broadrup M.D. M. D. or other
Address: Cumberland, Md Date signed: 9/22/40

EE BROADRUP

RECEIVED
OCT 7 1940
BUREAU V. S.

09288
9

# STATE OF MARYLAND—CERTIFICATE OF DEATH

**1. PLACE OF DEATH**

County Allegany WITHIN CORPORATE LIMITS Registration Dist. No.

Village or City Frostburg Miner's Hospital No. St., Ward (If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred yrs. mos. ds. How long in U.S. if of foreign birth? yrs. mos. ds.

**2. FULL NAME** Baby Girl Wine brenner If U. S. Veteran, specify WAR

(a) Residence: No. St., Ward. (Usual place of abode) If nonresident give city or town and State

## PERSONAL AND STATISTICAL PARTICULARS

3. SEX F.

4. COLOR OR RACE W.

5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (*write* the word) Baby

5a. If married, widowed, or divorced HUSBAND of (or) WIFE of

6. DATE OF BIRTH (month, day, and year) Sept. 4 1940

7. AGE Years — Months — Days — If LESS than 1 day, hrs. or min.

OCCUPATION

8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. —

9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.

10. Date deceased last worked at this occupation (month and year)

11. Total time (years) spent in this occupation

12. BIRTHPLACE (city or town) Frostburg (State or country) Md.

FATHER

13. NAME Rex Hermit Schaffer

14. BIRTHPLACE (city or town) Cumberland, (State or country) Md.

MOTHER

15. MAIDEN NAME Flossie Pearl Wine brenner

16. BIRTHPLACE (city or town) Allegany, (State or country) Md.

17. INFORMANT Mrs. Lloyd Wine brenner (Address) Borden mines Md.

18. BURIAL, ~~CREMATION, OR REMOVAL~~ Burial Place Borden mines, Md. Date Sept. 4th, 1940

19. UNDERTAKER Lloyd Wine brenner (Address) Borden mines, Md.

20. FILED Sept. 4, 1940 Mrs. A. R. Walker Registrar.

## MEDICAL CERTIFICATE OF DEATH

**21. DATE OF DEATH** Sept (Month) 4 (Day), 1940 (Year)

22. I HEREBY CERTIFY, That I attended deceased from Sept 4, 1940, to Sept 4, 1940

I last saw h elive on , 19 ; death is said to have occurred on the date stated above, at 4:30 A.M.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Still Birth

Date of onset

Other Contributory Causes of Importance:

Name of operation Date of

What test confirmed diagnosis? Was there an autopsy?

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? Date of injury , 19

Where did injury occur? (Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury

Nature of injury

24. Was disease or injury in any way related to occupation of deceased?

If so, specify

(Signed) A. M. Earle, M.D.

(Address) 60 W. Main St. Frostburg Md.

*If more blanks are needed, address State Registrar, 2411 N. Charles Street, Baltimore, Requesting U. S. No. 1.*

MARGIN RESERVED FOR BINDING

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

V. S. No. 1

# UNITED STATES STANDARD CERTIFICATE OF DEATH

**Statement of occupation.**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

8.—The trade, profession, or particular kind of work done.
9.—The industry or business in which the work was done.
10.—The month and year the deceased last worked at the occupation.
11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

**Statement of cause of death.**—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

**Example I**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Arteriosclerosis* | *1915* |
| *Chronic interstitial nephritis* | *1921* |
| *Cerebral hemorrhage* | *July 5, 1927* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gallstones* | *May 1, 1923* |
| | |
| | |

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**Example II**

| The principal cause of death and related causes of importance were as follows: | Date of onset |
|---|---|
| *Attack of epilepsy* | *1 week ago* |
| *Run over by street car* | *1 week ago* |
| *Peritonitis* | *3 days ago* |
| | |
| | |
| Other contributory causes of importance: | |
| *Gastroenteritis* | *1 year* |
| | |
| | |

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (S)

09289

## CERTIFICATE OF DEATH

Reg. Dist. No. 4

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

**1. PLACE OF DEATH:**
County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution or street address where death occurred: Allegany Hospital
How long in hospital or institution?

**2. USUAL RESIDENCE (HOME) OF DECEASED:**
(For newborn infants give residence of mother)
State: Maryland County: Allegany
City or town: Cumberland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 534 N. Centre St.
(If rural, give LOCATION)
2.(a) If veteran, name war

**3. (a) FULL NAME** Stillborn Wright

**3. (b) Social Security Number**

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| Female | White | Single |

6.(b) Name of husband or wife
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Sept 19 1940

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| — | — | — | — hrs. ..... min. |

9. Birthplace: Cumberland Md.
(Town, county, and state)
10. Usual occupation: none
11. Industry or business

FATHER
12. Name: Thos. P. Wright
13. Birthplace: Cumberland Md

MOTHER
14. Maiden name: Anna Folk
15. Birthplace: Cumberland Md

16. Informant: T. P. Wright
Address: Cumberland
17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept 19 '40 (month) (day) (year)
Cemetery or crematory: St Patrick Cem
Location: Cumberland Md
18. Funeral director: Louis Stein & Son
Address: Cumberland Md.
19. 9/19/ 1940 (Date rec'd by registrar) Joseph A. Franklin Registrar M.D.

## MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 19 1940, at 3 30/ A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 19 1940 to Sept. 19 1940
and that I last saw her alive on Stillborn 1940

| Immediate cause of death | DURATION |
|---|---|
| Intrauterine Asphyxia | |
| Due to | |
| Due to | |
| Other conditions | |

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Anthony T. Jones M.D.
M. D. or other
Address: 40 N. Liberty St. Date signed 9-19-40

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WITHIN CORPORATE LIMITS

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-d

## CERTIFICATE OF DEATH

09290

Reg. Dist. No. 4

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A15

**1. PLACE OF DEATH:**

County: Allegany

City or town: Cumberland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred: Memorial Hospital

How long in hospital or institution? 2 days

**2. USUAL RESIDENCE (HOME) OF DECEASED:**

(For newborn infants give residence of mother)

State: West Va. County: Mineral

City or town: Ridgeley West Va

(If outside city or town limits, write RURAL and give nearest town)

Street No. 30 River View Ave Ridgley W. Va

(If rural, give LOCATION)

2.(a) If veteran, name war

**3. (a) FULL NAME** Luther Zimmers

**3. (b) Social Security Number** None

| 4. Sex | 5. Color or race | 6.(a) Single, married, widowed, or divorced |
|---|---|---|
| male | White | married |

6.(b) Name of ~~husband~~ wife: Bertha Fogle

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.): March 23, 1870

| 8. AGE: Years | Months | Days | If less than one day |
|---|---|---|---|
| 70 | 4 | 14 | hrs. min. |

9. Birthplace: Bedford Pa (Town, county, and state)

10. Usual occupation: Retired Western Md. Engineer

11. Industry or business: Western Maryland R. R.

FATHER 12. Name: John Zimmers

13. Birthplace: Pa

MOTHER 14. Maiden name: Eliza Jane Shiffler

15. Birthplace: Pa

16. Informant: Lester Zimmers

Address: 30 River View ave - Ridgley West Va

17. Burial (Burial, cremation, or removal. Which?) Date thereof Sept - 10 - (1940) (month) (day) (year)

Cemetery or crematory: Fort Ashby -

Location: Fort Ashby West Va -

18. Funeral director: Louis Stein Inc -

Address: Cumberland Md

19. Sept. 10, 1940 J. P. Franklin M.D. (Date rec'd by registrar) Registrar

**MEDICAL CERTIFICATION**

20. DATE OF DEATH: Sept 7, 1940, at M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/5/40, 19, to 9/7, 1940

and that I last saw h.i.m. alive on 9/7, 1940

Immediate cause of death: Hypertensive cardio-vascular disease — DURATION: 1 yr.

Due to:

Due to:

Other conditions:

(Include pregnancy within 3 months of death)

Major findings of operation: none

Date of op.

Autopsy results: none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide: Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury: Injured at work?

23. SIGNATURE: D. R. Moore, M D

M. D. or other

Address: Medical Bldg Date signed: 9/9/40

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